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The national news publication of the Australian Medical Association

Victorian breakthrough no end to blame game

Inside

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REGULAR FEATURES

Former *Australian Medicine* editor Dominic Nagle has retired. Mr Nagle, who joined the AMA in 2008, has made an important contribution to the AMA's work representing the interests of medical practitioners and taking a national lead on public health issues. Among his many achievements, Mr Nagle undertook the monumental task of researching and writing *More Than Just a Union: A History of the AMA*, which was launched last year to mark the AMA's 50th anniversary.

Cover: AMA President Dr Steve Hambleton launches the *AMA Public Hospital Report Card 2013*, flanked by (l to r): AMA Victoria President Dr Stephen Parnis, AMA NSW President, Dr Brian Owler, AMA Queensland President Dr Alex Markwell, AMA Vice President, Professor Geoffrey Dobb, AMA WA President Dr Richard Choong, and AMA SA President Dr Peter Sharley.

Putting spirit into the alcohol debate

BY **AMA PRESIDENT DR STEVE HAMBLETON**

"The alcohol industry, here and overseas, projects itself as seeking a partnership with governments under the guise of encouraging community education and responsible drinking"

In this edition of *Australian Medicine*, you will read about the recent visit by Professor Sir Ian Gilmore, the noted alcohol reformer from the UK. The AMA hosted a presentation by Sir Ian at Parliament House in Canberra.

This was another in a long list of policy roundtables and forums on alcohol organised by the AMA in recent times.

The key to successful health advocacy is to stay on message and repeat the message over and over again until policymakers and alcohol consumers take note.

It is no secret that the AMA is concerned about the effects of alcohol on health and on society.

We do not want to demonise alcohol, or penalise safe and responsible drinking. It is our mission to curb excessive and harmful alcohol use.

Doctors are not wowsers. But the sad truth is that every day we see the physical, mental and social harm caused by excessive alcohol consumption. We see the long-term damage to health, accidents, violent attacks, depression and other mental health problems, and the breakdown of families and relationships.

Not everybody has an understanding of the extent of excessive and harmful alcohol use in Australia.

About 10 per cent of Australians put their health at long-term risk by drinking too much, and 20 per cent drink at a level that puts them at risk of harm and injury in the short term.

In particular, too many adolescents and teenagers are starting to drink alcohol. The earlier they start drinking, the more likely they will become problematic drinkers throughout their lives.

About 80 per cent of the alcohol consumed by young Australians is consumed in ways that put the drinker's health, and the health of others, at risk.

But it is too easy to suggest it is just a small group of individuals behaving badly. There is an equally large impact over the long term from chronic overconsumption in all age groups. Sadly, problems are even more pronounced in the more deprived locations and societal groups.

The alcohol industry has to step up to become more responsible about how it markets alcohol, especially to young people.

The alcohol industry, here and overseas, projects itself as seeking a partnership with governments under the guise of encouraging community education and responsible drinking.

Yet, the alcohol industry has consistently opposed regulation or effective measures that might reduce alcohol-related harms.

They want to avoid anything that might reduce their sales, particularly to an emerging market of young people who could become life-long consumers.

We need alcohol reform in Australia.

There is no silver-bullet solution. We need a multi-faceted and strategic policy approach to alcohol reform.

But the success of any alcohol reform will be undermined if the alcohol industry is allowed to continue its irresponsible marketing practices to lure young people into early and potentially harmful drinking patterns.

There must be an urgent review of the current regulatory approach to alcohol advertising.

The voluntary industry-administered self-regulatory approach has failed. In fact, it never worked.

Young people continue to be exposed to alcohol marketing at an unprecedented level, and from multiple sources.

It is vital that we reduce this exposure. It is vital that we help our kids become aware of the dangers of irresponsible and excessive alcohol consumption. It is vital that we steer them away from a lifetime of dependency on alcohol. We have to expose and eliminate the tricks that lure young people into a lifestyle of alcohol addiction.

The AMA is pushing for a Parliamentary Inquiry into this issue. The support for such an inquiry is growing. It is a very serious health and social issue for our future generations.

TO COMMENT CLICK HERE

Hospitals struggling as governments bicker

The AMA has called for an end to government squabbling over health funding amid evidence that public hospitals are making little headway in cutting emergency department and elective surgery waiting times.

Information compiled by the AMA shows the nation's hospitals are barely keeping up with the increased health needs of a growing population, underlining warnings from AMA President Dr Steve Hambleton that lives could be put at risk by any further cuts to hospital funding.

The *AMA Public Hospital Report Card 2013* found that more than a third of emergency department patients were not seen within half an hour of arrival during 2011-12, while elective surgery patients faced, on average, a five-week wait for treatment.

Dr Hambleton said the disappointing results showed that all levels of government had to do much more to boost the performance of public hospitals and improve the care of patients.

The AMA President said a key problem was that hospital capacity, measured in terms of the number of beds per population, had barely budged in recent years despite a hefty10 per cent increase in Commonwealth funding between 2008-09 and 2010-11.

According to the Report Card, there were just 2.6 public hospital beds for every 1000 people in 2010-11 – the same level as in 2009-10 – despite the addition of 872 beds.

Even more tellingly, there were only 18.9 beds for every 1000 Australians older than 65 years – the very age group where demand for health care is highest.

Dr Hambleton said the paucity of beds had a knock-on effect through the whole hospital system that put lives at risk: patients who needed to be admitted to hospital from emergency departments were being forced to wait on trolleys in corridors, and people needing elective surgery were facing unacceptable delays in treatment.

"If there's insufficient beds in the system, and we can't get people out of emergency, it does cause harm, and we do see unnecessary deaths," he said.

The AMA Report was released amid escalating tensions between Federal, State and Territory governments over health funding.

A decision by the Commonwealth late last week to reverse a planned cut to Victoria's health funding allocation – see page 6 – has only fuelled disagreement.

The issue has escalated into a full-blown threat to federal Labor's health reforms, after Prime Minister Julia Gillard warned the states she was prepared to scrap the two-year-old funding agreement if they persisted in their campaign to blame the Commonwealth for cuts to health services.

The Federal Government has sought to bypass conservative state governments to allocate extra health funds directly to hospitals.

Ms Gillard told the states that if the Commonwealth was forced into a further diversion of health funds directly to hospitals by their intransigence, one option was to tear up the National Health Reform Agreement, which was intended to bring an end to the funding blame game.

Dr Hambleton said it was time for governments to stop blaming each other and instead work together to improve health care.

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Hospitals struggling as governments bicker

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"The public hospital system is simply not meeting the clinical demands put upon it," he said. "Now is not the time to blame one another. Now is the time to engage with the clinicians and actually do something about it."

In 2009 the Federal, State and Territory governments jointly committed to achieving public hospital performance benchmarks, including that, by 2012-13, 80 per cent of emergency department patients would be seen within clinically recommended treatment times.

But the AMA report indicates that, as of 2011-12, most states and territories - with the exception of Western Australia – had a long way to go to reach their targets.

It found that just 66 per cent of urgent emergency department cases were seen within the recommended 30 minutes, and "no substantial progress is being made towards the target of 80 per cent" despite a Federal injection of $750 million.

The AMA report also shows that governments have failed in their commitment to keep the growth of bureaucracy in check, with administrative and clerical staff accounting for more than 15.5 per cent of the total health workforce, up from close to 15 per cent in 2009-10.

AMA Vice President Professor Geoffrey Dobb said the health reform agenda promised by Federal Labor had slowed to a halt.

AMA New South Wales President Dr Brian Owler said "what we've seen is reform to the governance, reform to the way our hospital system is budgeted and administered, but what we haven't seen is the reform filter through to the departments and to the individual level".

AR

Funding breakthrough, but blame game continues

The Federal Government has reversed course and reinstated $107 million of funding to Victorian hospitals.

But, in a sign of the serious deterioration in relations between the Commonwealth and the Victorian Government, the Federal Government will bypass the state health department and pay the funds directly to hospital administrators.

Federal Health Minister Tanya Plibersek said her Government had made the about-face because of the Baillieu Government's "blatant disregard" for Victorian hospital patients.

"The cash injection will be paid directly to Local Hospital Networks, which will distribute the money to ailing Victorian hospitals, and will not pass through the hands of the Baillieu Government, which has proven itself to be a cruel and incompetent manager of the Victorian health system," Ms Plibersek said.

Hospitals across the state had begun closing up to 350 beds and cancelling about 20,000 elective surgery procedures as a damaging political stoush erupted between the two governments over hospital funding.

The Federal Government announced last year it would cut its planned health funding allocation to Victoria by $107 million to reflect a downgrade in official population estimates for the state.

The Victorian Government, which had only just cut its health spending by $616 million, cried foul, and mounted a vigorous campaign against the Commonwealth over the issue, refusing to increase its health funding and directing hospitals to absorb the budget cut – leading to widespread bed closures and surgery cancellations.

Ms Plibersek said the Federal Government had reinstated the funds for this year to protect the interests of Victorian hospital patients.

"We believe we have an obligation to ensure Victorians are given the best possible health care," the Minister said. "We will not stand by and allow Premier Baillieu's politicking to hurt patients."

But the Commonwealth warned Victoria there would be a $55 million cut to its funding under the terms of the National Partnership Agreement.

Victorian Premier Ted Baillieu welcomed the Commonwealth's decision to abandon what he said were "unjustified" funding cuts, and called for the reinstatement of $475 million in funding over four years.

"There was never any justifiable reason for the imposition of these cuts," Mr Baillieu said.

The Federal Government has flagged it may take a similar approach to hospital funding in Queensland, where a brawl has erupted over the withdrawal of $103 million in planned Federal funding.

In a letter to Premier Campbell Newman, Prime Minister Julia Gillard said the Commonwealth would consider delivering $234 million of health funding direct to hospitals, bypassing the State Government.

AR

TO COMMENT CLICK HERE

Nothing cheerful about cheap booze

Governments have to tighten rules governing the price, marketing and availability of alcohol if they are to curb the harm caused by dangerous drinking, a leading international expert on alcohol reform has warned.

Renowned UK physician Professor Sir Ian Gilmore told an AMA forum on alcohol policy at Parliament House that the consumption of alcohol was driven by price, promotion and availability, and efforts to reduce harmful drinking needed to focus on the product, rather than blaming individuals and 'culture'.

His comments came against the backdrop of ongoing debate about controversial measures in the Northern Territory to ban alcohol from several Indigenous communities.

Sir Ian backed warnings from the AMA that the alcohol industry was actively promoting drinking among teenagers and adolescents, and needed to be subject to tough external regulation.

Studies in the UK and the Netherlands had shown that children were more likely to see alcohol ads than their parents, and many were specifically pitched to appeal to young people, he said.

AMA President Dr Steve Hambleton said the proliferation of such advertising, including through sports sponsorships, social media games and product promotions, was very worrying because such exposure could lead to damaging drinking habits.

"Too many adolescents and teenagers are starting to drink alcohol," Dr Hambleton said. "The earlier they start drinking, the more likely they will become problematic drinkers throughout their lives."

Sir Ian, a former President of the Royal College of Physicians and current Chair of the UK Alcohol Health Alliance and the European Alcohol Health Forum Science Group, linked Britain's position atop Europe's binge drinking table to marketing and to the ready availability of cheap booze.

Professor Sir Ian Gilmore at the AMA Alcohol Policy Forum, Parliament House

He said Britons, on average, drank 25 standard drinks a week – twice the amount they did in the 1950s - with serious effects on health, both in the short and long term.

Sir Ian said alcohol was the "number one risk factor" among those in the UK who died before 60 years of age - contributing to almost a third of all deaths of men aged between 16 and 25 years – though

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TO COMMENT CLICK HERE

Nothing cheerful about cheap booze

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"Too many adolescents and teenagers are starting to drink alcohol ... The earlier they start drinking, the more likely they will become problematic drinkers throughout their lives"

the peak period for alcohol-related deaths was between 45 and 65 years.

Sir Ian, who is a leading UK specialist on liver disease, said alcohol was not only linked to car fatalities, physical assaults and violence, but was also a major cause of chronic disease and fatality, noting that drinking caused 80 per cent of all deaths in the UK from liver disease.

He said it was these complaints, rather than injuries and accidents, that accounted for most of the one million admissions made to UK hospitals each year stemming from alcohol.

Sir Ian said the approach taken by the drinks industry to alcohol policy was to emphasise that its consumption was a normal part of life, and to try to confine any policy action to the relatively small section of the population deemed to be heavy drinkers.

But he said this merely protected the industry's own interests, and governments needed to take a much broader and more thoroughgoing approach.

"Alcohol is not ordinary. It is a drug of dependence," he said. "And the problem lies not with individuals, but the product."

He said that, as in Australia, industry self-regulation in alcohol advertising in the UK had been a failure, and he endorsed the AMA's call for a Parliamentary inquiry into the marketing of alcohol to young people.

Sir Ian said the promotion of alcohol and drinking in all its forms, from traditional advertising to sports sponsorship, product placement in television shows and films, through social media games and even mobile phone apps, was an important target of policy reform.

But he said equally significant in the UK was action on the cost of booze.

Sir Ian said the rise of heavy drinking in Britain had been driven by the availability of cheap alcohol sold by supermarkets and off-licences (bottle shops).

While the volume of alcohol sold through pubs, clubs and restaurants had remained relatively stagnant, it had surged through other outlets, with supermarkets using heavy discounts on wine, cider, spirits and other drinks to lure shoppers.

For example, he said, one retailer was selling three litres of alcoholic cider for the equivalent of $4.35.

Alcohol reform campaigners in the UK have been heartened by political moves to introduce a minimum unit price for booze.

Sir Ian said such a measure could be very effective, because it would raise the price of the very cheap drinks that were favoured by heavy drinkers, while not affecting the cost of beer and wine sold at pubs and restaurants.

The Scottish Parliament has approved an alcohol floor price of 50 pence, though it has yet to enact the legislation pending the outcome of legal challenges being mounted by the alcohol industry.

Just as promisingly, Sir Ian said, British Prime Minister David Cameron had thrown his support behind a minimum floor price in England, though at a lower rate of 45 pence per unit of alcohol.

Asked what had brought the British Government to this position after years of resistance to the idea, Sir Ian ascribed it to a slow build-up of pressure over time from reform advocates, combined with a serendipitous and unexpected circumstance.

He said the breakthrough came when an MP, who was a doctor, asked Mr Cameron during parliamentary Question Time about a minimum floor price on alcohol.

The Prime Minister then sought a briefing on the issue and threw his weight behind the proposal, which is yet to be submitted as a Bill.

Developments in the UK have leant fresh impetus to efforts in Australia to curb the visibility and availability of alcohol, particularly products targeted at the young.

Dr Hambleton said governments in Australia should take note of what is happening overseas, including in the UK.

"Young people continue to be exposed to alcohol marketing at an unprecedented level, and from multiple sources," the AMA President said. "It is vital that we reduce this exposure."

AR

Quality of care compromised by Defence contracts

The AMA has raised concerns that some doctors treating Australian Defence Force personnel are being left with no option but to write generic specialist referrals for their patients.

AMA President Dr Steve Hambleton said several medical officers working at Defence Force bases had been left feeling "compromised" by arrangements under which they are required to use a network of specialist providers approved by Medibank Health Solutions (MHS).

Dr Hambleton said there continued to be significant dissatisfaction among doctors with far-reaching changes to Defence medical care introduced by MHS after it won a $1.3 billion, four-year contract to provide health services for 80,000 ADF personnel and their families.

"MHS has made significant changes to the provision of medical services to ADF personnel – both on-base and off-base," Dr Hambleton said in a letter to AMA members earlier this month. "This has included fee cuts and the establishment of the new MHS network of 'preferred specialist providers'."

Dr Hambleton said there was particular concern that the MHS model of generic specialist referrals would compromise quality of care for ADF personnel.

"We are aware that, in some circumstances, on-base medical officers have had no alternative but to write generic referrals for specialist care, with MHS then attempting to find a specialist who will see the patient," he said. "Not surprisingly, many of these doctors feel compromised by this situation."

Dr Hambleton said the AMA had held several meetings with MHS to voice the serious concerns of its members, but the company was yet to "properly address" the issues raised.

MHS has met fierce resistance from medical groups and specialists to its plans, which include establishing a centralised database of preferred specialist providers, and a set of onerous demands, including fee cuts of up to 50 per cent and requirements that all medical reports be completed and lodged within three days.

While the company claims there has been a "good response" to its offer, an AMA survey conducted late last year found that fewer than one in 10 specialists had signed up, and members contacting the AMA since have continued to voice vehement objections to the MHS offer.

"I have not signed, nor will I sign, a contract that neither I nor my industrial representatives have had the opportunity to negotiate in an open and cooperative manner," said one member earlier this month, in a typical response.

The backlash against the MHS contracts has spread, with dentists and physiotherapists joining anaesthetists and orthopaedic surgeons in rejecting the company's offer.

While many doctors have expressed outrage at the unilateral fee cuts MHS has sought to impose, just as many have objected to a model of care they believe compromises their ability to manage the care of their patients.

"Never mind the dollars," said one, "the big issue is the severing of the connection between GP and specialist. The loser here is the patient, as they no longer benefit from their GP's assessment of who is the best specialist for the problem at hand."

Said another: "Decisions I make with, and on behalf of, my patients are carefully considered, and not the result of managed care. Referrals I wish to make to other health providers should likewise not be jeopardised by the limitations of the Medibank Health Solutions agreement."

In a sign that MHS is struggling to sign up the specialists its needs, doctors who have not accepted its offer report they are still having ADF personnel referred to them for treatment, and are being paid their normal rates.

Said one: "Despite not signing the Medibank Health Solutions agreement, I continue to provide sub-specialised orthopaedic services to members of the ADF. This is an enjoyable and challenging part of my practice and, for as long as I continue to be reimbursed for my services (as per my practice billing schedule and not the Medibank Health Solutions schedule), I will look forward to seeing more ADF personnel."

Dr Hambleton has asked doctors to provide evidence to the AMA, anonymously, about problems and concerns they have with the arrangements MHS has sought to introduce.

He said the AMA was monitoring the situation "very closely", and the response from members so far was "very much in support of the position the AMA has taken to this point".

Dr Hambleton advised members who had been offered MHS contracts not to feel pressured into signing up, and to seek independent legal advice be accepting the offer.

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TO COMMENT CLICK HERE

Funding overhaul for medical training

"A key concern is that there be sufficient teaching and training capacity to cope with rapid growth in the number of medical graduates"

Funding for medical teaching and training needs to be overhauled and enhanced to reflect its importance as "core business" for the health system, according to the AMA.

As the Independent Hospital Pricing Authority (IHPA) begins work on a funding model for medical teaching, training and research, the AMA has cautioned that any changes need to encourage and support what is a critical undertaking in sustaining quality health care.

Under the National Health Reform Agreement, the IHPA has until mid-2018 to advise the Standing Council on Health how to shift medical teaching, training and research to an activity-based funding system.

The IHPA has this month established a Working Group to look at the fixed and variable costs to hospitals of providing teaching, training and research services, and advise on how these should be classified.

The Authority expects the Working Group will do most of the conceptual work involved in the change through the next 12 months, with data collection to begin next year, with the possibility the new funding arrangements could be introduced during 2015 or 2016 – well inside the Agreement deadline.

AMA Vice President Professor Geoffrey Dobb said it was crucial that the shift to activity-based funding lead to greater support and resources for teaching and training.

"Current funding arrangements do not adequately reflect the costs of teaching and training," Professor Dobb said. "It is vital that we do more to support this critical activity in our public hospital system."

A key concern is that there be sufficient teaching and training capacity to cope with rapid growth in the number of medical graduates.

Professor Dobb said Health Workforce Australia estimates showed the nation was facing a shortfall of 450 first-year specialist training places by 2016 unless there was a significant lift in investment in teaching and training.

"We need to address the significant bottlenecks in the medical training pipeline that Health Workforce Australia is predicting as more and more much-needed medical graduates come through the system," Professor Dobb said. "We also need a funding model that delivers a quality clinical training experience from medical school right through to the completion of vocational training."

The AMA convened a high-level meeting of 13 organisations involved in medical education and training late last year to discuss the shift to activity-based funding.

The meeting agreed on a set of principles to guide the development of the new funding model, including that it should include recognition of the experience and skills of providers, that it be underpinned by publicly reported performance indicators, that it not create disincentives for training in settings other than public hospitals, and that it include consideration of whether funding should be attached to the trainee or allocated to the provider.

The meeting resolved that teaching, training and research should be seen as core business for the health system: "A culture of teaching and learning must be embedded in the public hospital system. Investment in teaching and training must be seen as essential to providing a quality service environment, and a sustainable health workforce."

Acknowledging the looming shortfall in medical training places, the meeting said it was "vital that pricing and funding is linked to health workforce planning and projections, to provide sufficient training capacity for medical graduates and trainees".

A statement of Objectives and Principles from the meeting can be viewed at: http://goo.gl/6xlmR

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Anaesthetists' skills undermined by senior doctor

Doctors were shocked and extraordinarily disappointed to read the reported comments of Dr Brendan Murphy in *The Age* newspaper recently about anaesthetists working in the Victorian health system.

Dr Murphy holds a senior position in a Melbourne hospital and is a member of the Health Workforce Australia (HWA) Board.

AMA President Dr Steve Hambleton said Dr Murphy's reported comments, in which he said that "for 99 per cent of the time [anaesthetists] are just squirting in drugs, putting someone to sleep", sent shockwaves through the medical profession all over the country.

"Dr Murphy publicly trashed the reputation of hard working and highly skilled doctors who play such a critical role in high quality patient care," Dr Hambleton said.

"The mortality rates for anaesthesia in Australia are well below the average for developed countries, and we know that significant improvements in anaesthetic care have led to a much improved experience for patients and better recovery times.

"By suggesting that nurses could take over the work of anaesthetists, the comments in *The Age* placed a low value on the skills that doctors bring to our public hospital workforce.

"It's hard to avoid the suspicion expressed by leading anesthetists that these comments were linked to current industrial negotiations in Victoria.

"As a doctor in senior clinical and administrative roles, Dr Murphy has a responsibility to be far more measured in what he has to say publicly about the health workforce."

Dr Hambleton raised the matter with the CEO of HWA, Mark Cormack, immediately after the comments were reported.

"I was pleased that Mr Cormack was able to reassure me that the comments in no way reflected the views of HWA or its agenda for workforce innovation.

"HWA is looking at collaborative models of care where other health professionals can utilise extended skills – but only within a medically supervised environment.

"We also know that expanding the role of nurses is not the answer to medical workforce shortages.

"According to HWA, the nursing profession is grappling with the prospect of a shortage of 109,000 nurses by 2025.

"Medical graduate numbers are now at record levels and we need to be focused on finding quality training positions for these graduates so that patients can access the quality care in our public hospitals that they deserve."

The original story in *The Age* is available at http://www.theage.com.au/victoria/nurses-take-on-doctors-tasks-20130209-2e5oy.html

JF

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Practices get green light for collective bargaining

The competition watchdog will allow GPs in a practice to act collectively setting fees and negotiating charges, in an important decision welcomed by the AMA.

Issuing its final determination on the issue late last week, the Australian Competition and Consumer Commission granted an exemption to allow GPs working in the same practice to agree on the fees charged to patients, and to negotiate collectively with hospitals and Medicare Locals on charges.

The authorisation will come into effect on 15 March.

AMA President Dr Steve Hambleton said the AMA had taken a leadership role on behalf of the profession in applying for the exemption, and was pleased the watchdog had accepted the Association's case.

"We want to ensure that GPs who engage in this type of conduct are not exposed to action under competition laws," Dr Hambleton said. "The decision will remove this uncertainty."

The ACCC has recognised the public benefits that flow from the granting of the application, including cost and administrative efficiencies, improved continuity and consistency of patient care, improved recruitment and retention of GPs, and the streamlining of negotiation processes with Medicare Locals and hospitals.

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AMA IN THE NEWS

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

Print/Online

Doctors claim lives in danger – crisis in emergency departments, *Herald Sun*, 16 February 2013

AMA President Dr Steve Hambleton said the AMA's annual Public Hospital Report Card showed there had been little improvement in performance despite a 10 per cent funding boost from the Federal Government, with patients having to wait 36 days on average for elective surgery and more than a third of emergency department patients having to wait more than 30 minutes to be seen.

Doctors plea over cutbacks to hospital funding, *Sydney Morning Herald*, 16 February 2013

AMA President Dr Steve Hambleton said the clear message from the findings of the AMA's annual Public Hospital Report Card was that no government should be reducing public hospital funding. Dr Hambleton called on governments to end the funding blame game and jointly assume responsibility for ensuring hospitals have the resources they need.

Young drinker danger, *Daily Telegraph*, 19 February 2013

The AMA has renewed calls for a Federal inquiry into alcohol marketing to young people, with President Dr Steve Hambleton warning that alcohol companies were grooming young people through advertisements and social media to "lock in" the next generation of drinkers.

Ire at brewers' dupe, *Hobart Mercury*, 19 February 2013

The AMA has raised concerns that alcohol companies are marketing their products to teenagers and young people, not only through traditional advertising, but also through the use of Facebook, product placement and other marketing methods.

Radio

Dr Steve Hambleton, 5AA Adelaide, 18 February 2013

AMA President Dr Steve Hambleton said it was becoming too easy for people to buy illegal substances, following the seizure of a record numbers of steroids by Customs officers in the past two years.

Dr Will Milford, 702 ABC Sydney, 19 February 2013

AMA Doctors in Training Council Chair Dr Will Milford said plans by Charles Sturt University to open a medical school had to be considered in the light of a looming shortage of 250 intern places for medical graduates. Dr Milford said the NSW Government had not matched intern places with the rising number of medical graduates, and the Commonwealth was yet to say whether it would repeat the injection of money for intern places that it provided late last year.

FM 104.7 Canberra, 19 February 2013

Doctors accuse alcohol brands of trying to lock in new customers while they are still under-age. The industry is allowed to self regulate when it comes to marketing to children, but the AMA says it isn't working, calling for tough new restrictions on ads and the use of Facebook.

Professor Sir Ian Gilmore, 3AW Melbourne, 18 February 2013

UK alcohol policy expert Professor Sir Ian Gilmore, who was guest speaker at an AMA forum on alcohol policy at Parliament House, said that although he was not here to lecture Australians about their drinking, experience in the UK had shown that when drinking hours were deregulated there was a surge in alcohol-related illness, violence and accidents, highlighting the fact that price and availability were the key drivers of drinking.

TV

Dr Hambleton, Channel 7 Sydney, 16 February 2013

AMA President Dr Steve Hambleton said that although public hospitals provided very good care, the AMA's annual Public Hospital Report Card showed that they were struggling to lift their performance, despite a hefty injection of Federal funds.

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AMA in action

AMA President Dr Steve Hambleton, Vice President Professor Geoffrey Dobb and AMA State Presidents Dr Alex Markwell (Queensland), Dr Brian Owler (NSW), Dr Stephen Parnis (Victoria), Dr Peter Sharley (South Australia) and Dr Richard Choong (Western Australia) pushed the destructiveness of the Federal-State health funding blame game and the struggles of public hospitals in meeting growing demand to the top of the national agenda with the release of the AMA's annual Public Hospital Report Card in Sydney on 15 February. Dr Hambleton told a big media contingent the Report Card showed there had been no improvement in hospital performance in 2011-12 despite a big lift in Federal funding, and each of the State AMA Presidents talked of the particular problems being experienced by public hospitals in their jurisdictions. Dr Hambleton also reiterated the AMA's call for a Parliamentary inquiry into the marketing of alcohol to young people at an alcohol policy forum organised and hosted by the AMA at Parliament House. The forum drew together leading alcohol policy experts from around the country, including Professor Mike Daube, Director of the McCusker Centre for Action on Alcohol and Youth. The forum was addressed by leading international expert on alcohol policy, Professor Sir Ian Gilmore. Sir Ian, a former President of the Royal College of Physicians, who has risen to international prominence in the last decade for his work to curb dangerous drinking, told the forum of the dimensions of the United Kingdom's alcohol problem, and recent progress toward bringing Britain's rampant drinking culture under some sort of control – particularly a push, backed by British Prime Minister David Cameron, for a minimum floor price for alcohol.

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AMA President Dr Steve Hambleton, backed by AMA leaders from around the country, launches AMA Public Hospital Report Card 2013

AMA WA President, Dr Richard Choong

AMA NSW President, Dr Brian Owler

AMA Queensland President, Dr Alex Markwell

AMA in action

AMA Vice President, Professor Geoffrey Dobb

AMA Victoria President, Dr Stephen Parnis

AMA President Dr Steve Hambleton addresses the AMA Alcohol Policy Forum, Parliament House

AMA SA President, Dr Peter Sharley

AMA Vice President Professor Geoffrey Dobb (l) with Professor Mike Daube, Direcotr, McCusker Centre for Action on Alcohol and Youth

AMA Vice President Professor Geoffrey Dobb (l) with Professor Sir Ian Gilmore and AMA President Dr Steve Hambleton (r)

AMA President Dr Steve Hambleton talks with Professor Sir Ian Gilmore at the AMA Alcohol Policy Forum, Parliament House

New Medicare Local head: passion for primary care

The woman appointed to steer the national system of Medicare Locals through the next stage of its evolution has what could be a reassuring message for clinicians.

Claire Austin, whose appointment as chief executive officer of the Australian Medicare Local Alliance (AML Alliance) was announced early this month, has a self-confessed passion for general practice and primary care.

"General practice and primary care have been at the heart of what I have done, and I have this ongoing passion for the area because I believe it can make a real difference," Ms Austin told *Australian Medicine*.

But the experienced health bureaucrat, who takes up her position with the AML Alliance early next month from her current job with Health Workforce Australia, will have some work to do to convince sceptical GPs that Medicare Locals will really improve support for both doctors and patients, rather than sideline practitioners and simply add another layer of bureaucracy.

AMA President Dr Steve Hambleton warned late last year that the Government was in danger of making a big mistake in the way it had gone about establishing Medicare Locals and putting them under the control of an overarching bureaucracy – the Alliance.

"Medicare Locals will only succeed with GP leadership and majority GP decision-making," Dr Hambleton said. "The Government is pursuing the wrong model by substituting the role of GP leaders in Medicare Locals and in their decision-making structures. They are not local enough, and they will not be responsive to local health needs unless they are fully engaged with GPs."

Ms Austin appears intent on doing what she can to allay doctor concerns, outlining a vision for Medicare Locals in which they are built around, and responsive to, local needs.

"They cannot be one size fits all, you need different solutions for different communities," Ms Austin said. "We are talking about a local process, a devolved process, that will embrace GPs and other health professionals as the best people to drive decisions."

The incoming AML Alliance CEO said one of the very first discussions she planned to have when she took on her new role was with the AMA, to understand its concerns in greater depth.

"It is very important to listen to what people's concerns are, and my professional history shows that I have always had a strong commitment to general practice and supporting GPs," she said. "GPs have a great deal to offer, so it is important to have this conversation."

But Ms Austin will have to fend off calls from the Opposition and the nation's biggest medical centre owner, Primary Health Care managing director Dr Ed Bateman, that Medicare Locals should be scrapped, and the money saved channelled into other areas of health care.

Dr Bateman early this month seized on Productivity Commission figures showing a 15 per cent drop in Government funding for GPs to argue that the Commonwealth should axe its $500 million outlay on Medicare Locals administration.

The Productivity Commission report showed that real Government spending on GPs had fallen from $353.10 per person in 2007 to $299.40 in 2012, which Dr Bateman said had increased the pressure on GPs, increased waiting times for treatment, and forced more patients into the hospital system.

But Ms Austin said Medicare Locals were a great opportunity to relieve pressure on hospitals by supporting GPs and primary carers in what they did best – providing preventive care and helping ensure minor ailments did not escalate into episodes requiring hospitalisation.

Incoming Medicare Local Alliance CEO Claire Austin

She said critics of the AML Alliance overlooked the very real benefits Medicare Locals could achieve for both doctors and their patients.

Ms Austin, whose curriculum vitae includes stints as CEO at both the Royal New Zealand College of General Practitioners and Victoria's Rural Workforce Agency, said the AML Alliance could bring much-needed coherence to a splintered health system.

"One thing that Medicare Local has had to offer, from its earliest days, is a huge opportunity to add value by creating some coherence to what is a very fragmented health care system" she said, adding this could be of huge benefit to doctors.

"It is very important to support those people who provide care, and that includes by minimising red tape and duplication," Ms Austin said.

She said she would "welcome" an opportunity to meet with Opposition MPs to discuss ways forward.

"There are some huge opportunities to look at ways to keep people out of hospital and keep people well," Ms Austin said. "I think its important to look at the outcome."

See also Medicare Local budget bid, p24

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New medical schools could worsen intern crisis

"... the number of graduating medical students had more than doubled since 2002, putting the capacity of the internship system under severe strain"

The AMA and the Australian Medical Students' Association have raised concerns about plans by two universities to open medical schools unless there is a significant boost in intern places.

Chair of the AMA Council of Doctors in Training Dr Will Milford has warned up to 250 medical graduates could be left in limbo this year unless federal and state governments committed to boosting the number of internships on offer, casting doubt on the current training system to accommodate even more trainee doctors.

Dr Milford made his warning as Western Australia's Curtin University and Charles Sturt University in rural NSW pushed ahead with their plans to open medical schools, a move that would add significantly to the number of medical graduates coming through the education system.

The WA Government, which is in the throes of a state election campaign, has pledged $22 million toward the construction of a medical school at Curtin University – though the Federal Government is yet to make any commitment to the project.

Health Minister Tanya Plibersek last year delivered a blow to the plans of both Curtin and Charles Sturt when she told the AMA it was "difficult to support" any proposed increase in medical school places in the current environment.

"In relation to proposals for new medical schools in Australia, I would like to assure you that the current position of the Commonwealth is that any proposed increase in medical places, whether via establishment of new medical schools or through allocation of new places at established schools, is difficult to support at this time," the Minister wrote in July last year. "It is essential that all governments continue to address their commitment to existing medical trainees, clinical supervisors and patients to increase capacity and maintain high quality training for the existing group of future medical practitioners, prior to making any decisions to increase the intake of medical students."

AMSA President Ben Veness said the number of graduating medical students had more than doubled since 2002, putting the capacity of the internship system under severe strain.

An internship is compulsory for medical graduates who want to go on to practice medicine, and more than a dozen graduates missed out on an internship last year because of the failure of governments to increase funding for places to match the growth in graduate numbers.

Mr Veness said only a last-minute bailout by the Federal Government prevented many more trainee doctors missing out on an internship.

Dr Milford called for much greater coordination among governments regarding medical training.

He told *ABC* radio in Sydney that the NSW Government had not matched the number of intern places it offered with number of medical graduates coming through the system, and the Commonwealth had yet to indicate whether it would step in again this year to help make up the shortfall in internships.

Dr Milford said that if it did not, up to 250 graduates might miss out on an internship.

Both the AMA and AMSA attended the National Medical Intern Summit, which was intended to bring together health ministers, medical deans and health bureaucrats from around the country, in Sydney on 22 February.

The summit was called to examine ways to increase the number of internships on offer in both the public and private health sectors.

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Weak start for PCEHR

The Federal Government has encountered a poor response so far from doctors and the public to the launch of its controversial electronic health record system.

Figures provided to the Opposition earlier this year show that fewer than 57,000 people have so far registered for a Personally Controlled Electronic Health Record, meaning almost 450,000 will have to sign up between now and the end of June to meet the Government's first year target of 500,000 registrations.

Nonetheless, the number of registrations is up substantially from last October, when just 13,400 people had signed up to the system, and Health Department Secretary Jane Halton said at the time that registrations were not expected to increase significantly until software for GPs became available.

Medical practices have been given until May to make themselves PCEHR-ready, but Government figures show the vast majority are yet to register with the system.

The Opposition's e-health spokesman Dr Andrew Southcott told the *Sun Herald* that information supplied by the Government in answer to a Question on Notice showed that, of 560,000 practitioners nationwide, just 1325 had registered so far.

According to the Health Department's timetable, most of the major software vendors to medical practices were to have developed desktop products with PCEHR functions by last December, and the Government has threatened to withdraw Practice Incentive Program e-health payments from practices that are not PCEHR-ready by May.

But the AMA declared that practices should not be penalised because of delays in providing them with the software they need to link in with the PCEHR system.

AMA President Dr Steve Hambleton said the Government should provide greater assistance for practices in preparing themselves for the e-health system.

"The AMA supports the PCEHR – it can make a real difference to the continuity of care for patients," Dr Hambleton said. "But the legal framework for the PCEHR has imposed additional red tape on practices. The Government can alleviate this by assisting practices to navigate the complex pathways and requirements necessary for them to participate."

In its Budget Submission, the AMA called on the Government to provide a single set of standardised template policies and protocols detailing what is required to participate in the PCEHR.

"This would save significant administrative time and resources for medical practices, which would otherwise have to prepare these documents from scratch," the Submission said. "Government funding should be provided to an entity that understands the clinical and administrative operations of medical practices to prepare these template documents.

"The Government should provide a standardised step-by-step toolkit to streamline the processes that medical practices will have to put in place to meet the administrative and technological requirements of the PCEHR."

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Tasmania considers 'assisted dying'

Tasmanian doctors will be empowered to administer lethal doses of medication to terminally ill patients under controversial proposals developed by Premier Lara Giddings.

In a discussion paper released earlier this month, Ms Giddings and Tasmanian Greens MP Nick McKim outlined measures to make "voluntary assisted dying" legal in Tasmania.

Under their proposal, mentally competent, terminally ill adults could seek assistance from a consenting doctor to die by taking a lethal dose of medicine, administered either by themselves or their doctor.

"Voluntary assisted dying is a complex issue that evokes strong emotions and generates intense debate," the MPs said. "[But] we believe it is important and necessary to enact legislation that fully demonstrates the compassion we all feel for people who are suffering in extremely difficult circumstances at the end of their lives."

Doctors would play a crucial, but voluntary, role under the arrangements envisaged by Ms Giddings and Mr McKim.

Medical practitioners would be central to a system of safeguards intended to ensure that only patients in the final stages of an incurable illness who are fully aware of what they are asking for, can be assisted in dying.

Both a patient's attending doctor and a consulting practitioner must attest to their mental competence, sign a declaration that the patient has been fully informed of their diagnosis, prognosis, the potential risks and likely outcomes of taking the prescribed medication, and feasible alternatives to assisted dying.

Both doctors must confirm that the patient is terminally ill, defined as being in the advanced stages of an incurable and progressive medical condition that can be reasonably expected to be fatal without significant medical intervention.

Under the plan, the attending doctor can only write a prescription for lethal medication 14 days after the patient has been declared eligible for assisted dying, and the medicine itself must be kept under the supervision of the prescribing doctor.

The medication should not be provided to the patient until they choose to take it, and the doctor must be present at death, to either supervise the patient in taking the medicine themselves, or to administer it where the patient is unable to do so.

Under their plan, Ms Giddings and Mr McKim emphasise that it would be entirely up to individual doctors whether or not they chose to participate.

Anticipating that, if the proposed laws are adopted, Tasmania might be flooded by people from interstate and overseas seeking an assisted death, the politicians specify that only Tasmanian residents – those who own or lease property in the State, have a Tasmanian driver's licence or who are on the electoral roll in Tasmania - would be eligible for assisted dying.

But in practice, this is unlikely to present much of a barrier, because a person can be added to the electoral roll after living at the same address for a month.

If such proposals are enacted, they could provide a much easier alternative for people like Martin Burgess, a 69-year-old retiree from the Northern Territory, who plans to fly to Switzerland to take advantage of that country's right-to-die laws.

Mr Burgess, who has rectal cancer that has spread to his abdomen and has been advised he will be dead within 18 months, told *Northern Territory News* he wanted to go to Switzerland to ensure he had a "painless and peaceful" death.

Voluntary assisted suicide was legalised in the Northern Territory in 1995, but Federal Parliament overturned the law in 1997.

In recent months there has been an upsurge in efforts to reinstate and extend right-to-die laws.

In addition to the Tasmanian Premier's action, the Australian Greens have moved a Bill in the Senate to repeal the Euthanasia Laws Act 1997, which outlawed the practice in the territories.

In South Australia, independent MP Bob Such has moved to ban the withdrawal of feeding tubes and saline drips as a way of hastening death unless other life-sustaining measures such as ventilators are also removed.

Dr Such said his proposed laws were intended to end the "cruel" situation in which people denied the right to decide to end their own lives were instead essentially starved to death.

But there remains considerable resistance to the legalisation of euthanasia, which continues to be a politically-fraught issue.

Among the most frequently voiced concerns are that people with diminished mental or physical capacity may be railroaded into agreeing to assisted dying.

But Ms Giddings and Mr McKim said international experience with euthanasia laws had shown little evidence that this occurred, and the sort of safeguards they envisaged would ensure the vulnerable were protected.

"We have not been able to find any sound evidence that there is a heightened risk for people who may be vulnerable due to their age, disability, mental illness or isolation, as a result of assisted dying legislation," they said. "Consistently expressed fears about voluntary assisted dying law reform have been found, in practice, to be unjustified."

Ms Giddings and Mr McKim have invited public comment on their proposal, which can be viewed at: http://www.premier.tas.gov.au/__data/assets/pdf_file/0007/185578/Voluntary_Assisted_Dying_-_A_Proposal_for_Tasmania.pdf

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Insurance increase fuels cover concern

The Federal Government has approved an average private health insurance premium increase of 5.6 per cent, to come into effect from 1 April.

The increase, combined with the decision to remove the rebate from Lifetime Health Cover penalty loadings, has fuelled industry concerns that many people will drop their cover, and the long-term trend among many fund members to wind back the level of their cover and opt for higher excess policies will accelerate.

Health Minister Tanya Plibersek said the average premium increase, of around $3.70 a week for families and $1.70 a week for singles, reflected rising costs for health funds.

Ms Plibersek said that, while the premium hike was about double the rate of inflation, the average payout from insurers had surged 9.3 per cent in the past year.

"They [the funds] are contributing a lot more back than they have in previous years," the Minister said.

Figures released by the Private Health Insurance Administration Council show that in the past three years the proportion of no-gap hospital medical services has climbed from 83.9 per cent to 88.5 per cent and, where there is a gap, the average payment has held steady at around $182 for the past year.

Ms Plibersek said competitive pressures had helped keep the scale of private health insurance premium increases down.

"One of the things that keeps the system healthy is strong competition, and we've put a big emphasis on making it easier for members of health funds to swap funds and to really allow people to compare and contrast policies," Ms Plibersek told *The Australian*. "We are very keen to ensure private health insurance remains competitive, and we are very keen to keep costs down."

According to *The Australian Financial Review*, the nation's two largest health funds plan premium increases above the average approved by the Government.

Medibank Private has indicated its premiums will rise by an average of 6.2 per cent, while Bupa will implement an average 5.8 per cent increase.

Private Healthcare Australia chief executive, Dr Michael Armitage, told the *AFR* the premium increases were being driven by rising costs.

"It is an extraordinarily competitive industry, and so all my CEOs know if they put their premiums up too much, people will change [funds]," Dr Armitage said.

In a submission to a Senate inquiry into Government changes to private health insurance arrangements, Dr Armitage warned 1.1 million policyholders would be hit by premium increases by the proposed rebate cut for Lifetime Health Cover loadings.

He said this would "inevitably" convince many people to either downgrade their health cover, or scrap it altogether.

But Ms Plibersek has repeatedly pointed out that fears that the imposition of a means test on the Private Health Insurance rebate would spark an exodus from the health funds had so far proven to be misplaced, with funds actually showing an increase in membership.

But industry figures warn that the full impact of the means test might not become apparent until later this year, when many high income earners who last year paid their insurance premiums up to 18 months in advance in order to pre-empt the policy change, will have their next, revised premiums fall due.

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PIP implants 'substandard' but not toxic: British report

The medicines watchdog has reaffirmed its ban on Poly Implant Prothese breast implants despite a British report that has cleared them of posing a significant health risk.

The Therapeutic Goods Administration has advised women with PIP implants to see their doctor, even though a report by the medical director of United Kingdom's National Health Service, Sir Bruce Keogh, found there was no evidence they caused cell damage or genetic mutations.

According to the British study, released early this month, PIP implants were "significantly more likely" to rupture or leak than other brands.

In his report, Sir Bruce said PIP implants were up to six times more likely to fail than the alternatives within the first five years of implantation.

The failure rate of PIP implants in their first five years was put at between 6 and 12 per cent, rising up to 30 per cent after 10 years. By comparison, the rupture rate for Allergan implants was put at 10 per cent after 10 years, and for Mentor implants, 14 per cent after eight years.

But the NHS medical director said the idea that PIP implants could slowly leak silicon and other substances into the body over years without being detected was not supported by the evidence.

"In a proportion of cases, failure of the PIP implant results in local reactions, but these are readily detected by outward clinical signs," Sir Bruce said. "'Silent' ruptures (which come to light only on explantation) are not generally associated with these local reactions."

The British report also sought to allay concerns that any material that leached into the body from a ruptured PIP implant could cause cancer or other serious illnesses.

"PIP implants are not associated with a higher risk of breast cancer or other forms of cancer than other breast implants," it said, adding that, "standard toxicological tests carried out in the UK, France and Australia showed no evidence of cytotoxicity (damage to cells) or genotoxicity (genetic mutations)".

Furthermore, the report said tests commissioned by Australian authorities had found there was no evidence that PIP implants caused skin irritation, contradicting claims made by French regulators when they were first recalled from the international market.

Sir Bruce said that, in sum, "PIP implants are clearly substandard, although there is no evidence of a significant increased risk of clinical problems in the absence of rupture".

In its latest update, the TGA reported that of about 13,000 PIP implants supplied in Australia between 1998 and 2010, there were currently 451 confirmed incidents of rupture, and 22 unconfirmed, and most commonly occurred between four and seven years following implantation.

The regulator said there was nothing in Sir Bruce's report to change its advice that women who had, or suspected they had, PIP implants, should see their doctor, but did not recommend that they be automatically removed, whether they had ruptured or not.

"The TGA has reviewed the report and determined that there is no new information that requires a change to the current advice," the watchdog said. "Testing undertaken by TGA has not found evidence that the risks involved with the use of PIP breast implants are any greater than those for any other brand of silicone gel-filled breast implants."

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Surgical pioneer leaves living legacy

Groundbreaking transplant surgeon Don Esmore, credited with saving the lives of more than 1500 heart and lung patients, has died.

Professor Esmore, who achieved renown for his highly skilled work at Victoria's Alfred Hospital heart and lung transplant unit over more than two decades, died early this month.

He had been battling bone marrow cancer, which was first diagnosed in 2002.

One of his closest colleagues, Professor Trevor Williams, told the *Herald Sun* that Professor Esmore's skill was only surpassed by his dedication.

"His legacy is 1500-plus people that have had life-saving transplants here at The Alfred, and probably 10,000 more open heart patients who have had their lives saved by his expertise," Professor Williams said.

"He was able to make the impossible possible, and things we had assumed just could not happen he was able to take on and prove they could be done."

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Company wins patent on cancer gene

Access to advanced cancer tests and treatments could be stunted after a court granted an American company a patent over human genetic material.

In a landmark ruling which has drawn worldwide interest, the Federal Court earlier this month upheld a claim by US firm Myriad Genetics to a patent on the so-called breast cancer gene, BRCA1 – which is thought to account for about 45 per cent of hereditary breast cancer.

Justice John Nicholas found that the removal of nucleic acid from its natural environment was an artificial state of affairs and therefore patentable.

Basing its reasoning on Australian case law, the court found that, in the absence of human intervention, naturally occurring nucleic acid does not exist outside the cell and thus "isolated" nucleic acid does not exist inside the cell.

Myriad was defending its patent claim against action by cancer advocacy Cancer Voices Australia and cancer survivor Yvonne D'Arcy.

Law firm Maurice Blackburn presented their case, arguing that mutations in the BRCA1 gene were a naturally occurring component of the human body that had been discovered, rather than invented.

But in his ruling, Justice Nicholas said it was mistaken to assume that, just because a gene mutation was part of the human body, isolating it could not be considered to fall within the High Court's broad definition of "new manufacture".

Cancer Council Australia chief executive officer, Dr Ian Olver, said the ruling highlighted the shortcomings in current patent law and warned the decision could hinder cancer detection and treatment.

"Discovering and isolating genetic materials is not inventive, yet the current law gives licence to biotechnology companies to claim ownership of naturally occurring substances," Dr Olver said.

He said the case had its roots in an attempt by Genetic Technologies in 2008 to monopolise diagnostic tests for BRCA 1 and BRCA2 genetic mutations by demanding public hospitals cease all such testing.

The company eventually backed down following widespread outrage, but Dr Olver warned there was little to stop a similar situation arising again where companies were granted the monopoly on genes.

"Genetic science will hold the key to major breakthroughs in cancer detection and treatment," he said. "If we don't change the law now to protect the community from gene monopolies, what almost occurred in 2008 could become commonplace – a handful of commercial interests owning the genetic materials essential to cancer detection and treatment."

Interest in the decision is high in the United States, where the Supreme Court is set to hear a high profile lawsuit involving patents on both the BRCA 1 and BRCA2 genetic mutations in April.

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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

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Multi-million dollar subsidy for hepatitis C drugs

More than 130,000 patients suffering hepatitis C, diabetes, osteoporosis and other serious conditions will have access to new and better treatments after the Federal Government added and extended subsidies for five medicines.

Two significant new treatments for hepatitis C, boceprevir and telaprevir, have been listed in the Pharmaceutical Benefits Scheme in a move Health Minister Tanya Plibersek said represented a major advance in the treatment of adults with the chronic condition.

"These breakthrough medicines represent a new hope for patients with hepatitis C," Ms Plibersek said. "These medicines could double the cure rate, and shorten the treatment duration by six months."

Hepatitis C is one of the most commonly reported notifiable diseases in Australia, with more than 300,000 people exposed to the virus, and at least 220,000 living with a chronic condition.

There is currently no vaccine for the virus, which causes life-threatening problems including liver failure and liver cancer, and it can only be managed through medication.

Ms Plibersek said more than $220 million had been allocated over five years to subsidise the two medications, which would otherwise cost patients up to $78,000 a year.

In addition to the hepatitis C treatments, the Government has also approved subsidies for the oral contraceptive levonorgestrel with ethinyloestradiol, the Parkinson's disease treatment rotigotine, and the diabetes 2 and cholesterol medication sitagliptin with simvastatin.

It has extended the subsidy for the osteoporosis medicine strontium ranelate to include men aged at least 70 years suffering problems with bone mineral density.

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Whooping cough claims land homeopath in trouble

The consumer watchdog has launched legal action against a homeopathy website that claims the whooping cough vaccine is "largely ineffective" and promotes homeopathic remedies as a safe alternative.

The Australian Competition and Consumer Commission has initiated Federal Court proceedings against the Homeopathy Plus! website over "allegedly misleading" claims regarding the pertussis vaccine.

"The claims on the website include statements that the whooping cough vaccine is 'unreliable' and 'largely ineffective' in preventing whooping cough, and that homeopathic remedies are a safe and effective alternative for the prevention and treatment of whooping cough," the ACCC said.

In its legal action, the regulator alleges the claims are misleading and deceptive, and has sought an injunction to have them removed.

It is also seeking to have penalties imposed on the company and individuals.

"Whooping cough is a highly infectious respiratory disease which is most serious in young children," the ACCC said. "The Australian Government Department of Health and Ageing recommends children receive the whooping cough vaccine as part of routine childhood immunisation."

In a notice on its website, Homeopathy Plus! advised that the ACCC's legal proceedings name Homeopathy Plus Australia Pty Ltd and homeopath Fran Sheffield.

"These complaints concern articles on the Homeopathy Plus! website about the effectiveness of the whooping cough vaccine and the homeopathic approach to the treatment and prevention of whooping cough," it said.

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Steroids flood in as hunt for sports dopers expands

Border Protection officials have reported a huge surge in the detection of illegal steroids and hormones as anti-doping authorities undertake a massive investigation into the use of performance enhancing drugs in sport.

As the sporting community continues to absorb the full ramifications of the Australian Crime Commission's explosive allegations of widespread doping and criminal involvement in sport, figures compiled by the Australian Customs and Border Protection Service – reported in the *Daily Telegraph* - show there was a 255 per cent jump in the seizure of illegally imported hormones and steroids between 2010 and 2012.

Customs reported that 2696 parcels containing performance and image enhancing drugs (PIEDs) were detected and seized in 2010, mainly in shipping containers and through the postal system, with the number soaring to 8721 last year.

In a sign that there has been no let-up in activity, Customs reported that 750 grams of PIEDs were seized at Port Lincoln on 30 January, and a man at Perth Airport was detected trying to bring 3700 tablets of anabolic and androgenic drugs from Thailand on 24 January.

The seizures have come against the backdrop of a number of investigations that have been launched into drugs in sport.

Earlier this month the Australian Sports Anti-Doping Authority (ASADA) announced that it planned to interview about 150 players, support staff and administrators from two major sporting codes – believed to be the Australian Football League and the National Rugby League – as part of its investigations.

In a brief statement, the Authority said that the "scope and magnitude of its investigation is unprecedented", and warned that "the number of interviews may grow if the investigation uncovers new lines of inquiry".

In a frustrating prospect for players, club medical officers, administrators and fans, ASADA cautioned that its investigation was "both complex and wide-ranging, and will take many months to complete".

So far, the Essendon Football Club has outed itself as one of the clubs under investigation, and ASADA confirmed it met with Essendon players and staff last week. But it has steadfastly refused to identify other clubs and individuals included in its enquiry.

"Until such time as ASADA concludes its investigation, it is not in a position to elaborate on the extent of the issue," the Authority said. "ASADA is unable to talk publicly about its investigation, and that includes speculating about, or naming, clubs or individuals until such time as its legislation permits."

The issue has ignited debate about the qualifications and certification of sports scientists, and the relationship between them and club doctors at sporting clubs.

Several prominent sports physicians have voiced concerns that club doctors, in part because they are employed part-time, have become increasingly marginalised at clubs by sports scientists, who in many cases are full-time employees.

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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

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Medicare Local budget bid to tackle chronic disease

The Australian Medicare Local Alliance has made a half-billion dollar bid for measures to detect and prevent chronic disease and ensure a healthy start to life for children.

In its submission for the May Budget, the Alliance has proposed the Federal Government commit $612 million over fours years to fund three measures it argues will deliver a massive return in reduced chronic disease.

Among its recommendations, the AML Alliance has suggested the Government set aside funds for a chronic disease detection program involving the application of Absolute Risk guidelines and assessment tools in one single patient assessment.

Alliance chair, Dr Arn Sprogis, said this would allow for the prevention and early detection of chronic conditions including cardiovascular disease, type 2 diabetes and kidney disease, and facilitate effective interventions.

The Alliance said these efforts should be backed by the commitment of $520 million over four years for the establishment of a national network of chronic disease care coordinators to improve patient access to prevention programs and multidisciplinary care, while a further $92 million should be spent over three years to help multiple services and agencies to provide systematic care for young children.

Dr Sprogis said improving population health was an efficient and effective way to achieve better health outcomes.

He said billions of dollars were being spent each year on the treatment of chronic diseases, and spiralling costs would "inevitably place an unsustainable strain on Australia's health system".

Dr Sprogis said the primary health care system was uniquely placed to implement preventive strategies and take a systematic approach to population health.

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Protecting the fundamentals

BY **DR BRIAN MORTON**

In recent weeks, the medical media has been abuzz with the health professions' proposals for the 2013-14 Federal Budget, due to be announced in May.

The Pharmacy Guild, for example, is making a real push for pharmacist-led vaccinations.

Curiously, a recent poll, which was showing that the majority of respondents were against pharmacist administered vaccinations, had to be pulled when over 200 votes contrary to the trend were cast within a few hours.

An ensuing investigation traced these votes back to a URL owned by the Pharmacy Guild of Australia, Queensland Branch, through which multiple computers and mobile devices had access.

The Royal Australian College of General Practitioners is advocating voluntary patient registration to formalise the link between a patient and their GP or general practice, to underpin a possible model for funding GP care outside of the consult.

The AMA is naturally cautious of ideas that would fragment care, or would ultimately ration it.

Consideration of these ideas needs to be extensive, with a maximum of consultation with GPs and patients.

Unless there are decisive benefits for patients and GPs, and unless the independence of the GP is preserved, such changes should not be implemented.

The AMA Council of General Practitioners Executive is considering these issues shortly in the context of its discussion of 'medical homes'.

The AMA Federal Budget Submission is built around protecting and supporting the most fundamental relationship in the health system – that between the doctor and the patient – and keeping it free of unnecessary government intervention.

This is an especially important priority in what is shaping as a politically turbulent year, with budget restraint thrown in.

In protecting and supporting the fundamentals of the health system, the AMA Federal Budget Submission proposes to support general practice in the following ways:

- increase the Practice Incentive Payment for teaching medical students to $200 per teaching session, so that it better reflects the costs to general practice of teaching medical students;
- increase the number of places in the Prevocational GP Placements Program to 1500 places a year by 2016, supporting more junior doctors to have a quality general practice experience;
- increase the GP training program intake to 1500 places a year by 2016;
- improve Medicare Benefits Schedule (MBS) rebates and streamline MBS arrangements to improve access for patients with mental illness to their GP or psychiatrist;
- higher MBS rebates for services that reflect the time and complexity of providing ongoing medical and dementia care to older people living in aged care facilities and in the community;
- additional funding to encourage and subsidise arrangements between aged care providers and medical practitioners, to ensure ongoing access to medical care in residential aged care;
- introduce MBS rebates specifically for the medical care provided to people at the end of their lives;
- extend MBS telehealth items to GP consultations for remote Indigenous Australians, aged care residents, people with mobility problems, and rural people who live some distance from GPs;
- develop a broad coordinated care program to tackle chronic and complex diseases, based on the model of care and funding arrangements developed for the Department of Veterans Affairs Coordinated Veterans Care Program;
- provide an additional 600 GP infrastructure grants at current funding levels (on average, approximately $300,000 each), enabling a third round of GP infrastructure grants;
- support GPs and GP practices to participate in the PCEHR by providing a single set of adaptable, standardised template policies and protocols detailing what is required to participate in the PCEHR;
- provide a standardised, step-by-step toolkit to streamline the processes that practices have to put in place to meet the administrative and technological requirements of the PCEHR; and
- remove the PBS Authority system.

The AMA will continue to advocate the need to ensure that the fundamentals of our health system are properly funded and supported.

TO COMMENT CLICK HERE

The rural doctor drought – is any relief in sight?

BY **DR DAVID RIVETT**

"In all, it is a half-baked system that has enormous potential, but which is likely to take perhaps a decade more than it should to become a meaningful contributor to patients' care"

One can but react with concern to the news that, after a flurry of meetings called by the Department of Health and Ageing at the end of 2012 on the rural workforce crisis, the announcement of any recommendations is not likely until some time in March.

This makes it exceedingly difficult for funds for any policies that come out of the process to be included in the Federal Budget on 14 May.

One can only hope that the Government's actions, when they do respond to the recommendations of the review of rural workforce programs, are substantial, expedient and on target.

One must also hope for a similarly useful response to the recommendations of the recent Senate inquiry into factors affecting the supply of health services and medical professionals in rural areas.

Medicare Locals, we are told, have been given funding for GP after hours care that is around 60 per cent greater than that provided through the Practice Incentives Program (PIP) and the General Practice After Hours (GPAH) program. Given GPs are being assured, particularly by rural Medicare Locals, that they will receive the same funding as under PIP, it will be important to monitor how the additional funding is spent.

PIP funding has never been sufficient to provide a sound business case for providing after hours care. Rather, it has been a small token of appreciation for those who do so.

Rural after hours care is a vital community service, and the funding for it should be fully passed on to those providing it.

So, if you are not convinced your Medicare Local is making appropriate use of the additional funding, let them know.

The future of accreditation must be in doubt, with two major PIP payments – after hours care and IT provision - both being changed drastically. One has been withdrawn and passed to MLs, and the other has been tied to a huge increase in red tape, with few, if any, positive outcomes likely for many, many years. Many GPs will now question the considerable costs of accreditation, and say no more.

And speaking of the Personally Controlled Electronic Health Record (PCEHR), why are the states not being bludgeoned into providing in-hospital data for the system? And why are many of our non-GP specialist colleagues not being given incentives to sign up?

In all, it is a half-baked system that has enormous potential, but which is likely to take perhaps a decade more than it should to become a meaningful contributor to patients' care.

And the PCEHR cannot fly without internet access, something which broke down completely in my neck of the woods throughout January when the Canberra holiday hordes hit the coast with their electronic devices. It is fine to have a fancy train, but useless if it has no tracks to run on.

On the good news front, it was pleasing to see that that piece of equipment seemingly designed by a committee to make life difficult, has been redesigned to make it user friendly.

Yes, the Mirena IUD is about to be reborn.

TO COMMENT CLICK HERE

Authority script rules lack rationale

BY **PROFESSOR GEOFFREY DOBB**

"... the AMA is monitoring the development of the joint therapeutics regulatory system that will be implemented under the new Australia and New Zealand Therapeutic Products Agency (ANZTPA), replacing the TGA and Medsafe in 2016"

Last year I wrote about the AMA's lobbying activities to remove the requirement for medical practitioners to obtain a Medicare authority number for many PBS medicines.

I met with senior Government officials in December in an effort to find out what had caused lengthy delays calling the Department of Human Services' Authority Freecall service, and to better understand the Government's ongoing attachment to the authority system in the absence of substantial evidence in its favour.

I was assured that only a very small proportion of medical practitioners wait more than 30 seconds for the call to be answered. However, when 600,000 medical practitioners call every month, that statistically small proportion still means too many individuals waiting too long.

If the Government imposes this policy, then the service must improve.

It was also disappointing that while there may be good reason for a small number of PBS medicines to need closer monitoring, there appears to be no systematic monitoring and analysis of the utilisation of PBS authority-required medicines and the impact of this policy.

In fact, we have learned that the Department of Health and Ageing does not maintain a working list of PBS medicines under authority-required and streamlined arrangements.

On the subject of regulation, the AMA is monitoring the development of the joint therapeutics regulatory system that will be implemented under the new Australia and New Zealand Therapeutic Products Agency (ANZTPA), replacing the TGA and Medsafe in 2016.

The first consultation paper seeking public comment was released in January. It provides a high-level overview of the proposed joint regulatory framework, consistent with current arrangements operating in Australia.

We will be interested in the detailed papers focusing on regulatory arrangements for advertising, the scheduling of medicines, and medical devices compliance that will be released later for public consultation.

Finally, Health Workforce Australia's (HWA) project to develop a nationally consistent 'pathway' for registered non-medical health professionals to prescribe safely has entered its last phase.

HWA has released a final consultation paper proposing a 'pathway' requiring accredited education and training, endorsement from the relevant National Board, prescribing within scope of practice, and ongoing education.

As a result, the draft 'pathway' addresses many of the AMA's earlier concerns.

However, even in the context of a considered approach to non-medical prescribing, the AMA's view is that prescribing by non-medical health professionals should only occur within a medically led and delegated team environment. As a result, we cannot support the 'autonomous prescribing' model currently described in the 'pathway' draft.

Our rationale for this view can be found in the AMA's submission to the HWA made at the beginning of this project in May 2012, which can be viewed at [https://ama.com.au/submission-hwa-prescribing-pathways-project] to HWA made at the beginning of this project.

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Tomorrow's doctors want #socialjustice today

BY **AMSA PRESIDENT BEN VENESS**

Social media, especially Facebook, are an important tool used by the AMSA National Executive to communicate with the 17,000 medical students we represent.

Over the past couple of weeks, one of the most popular posts on our page was a copy of a Letter to the Editor of A*ustralian Doctor*.

We sent it in response to a story they had published about Dr Lachlan Dunjey, the leader of "Doctors for the Family", who campaigned last year against equal marriage rights for all Australians.

Someone had lodged a complaint with the Medical Board about Dr Dunjey's submission to the Senate inquiry into marriage equality, apparently on the grounds that he misrepresented the scientific evidence.

Our post was seen by more than 1800 Facebook users. *Australian Doctor* chose to selectively publish quotes from our letter in a follow-up article, so Facebook was very helpful in reaching many more medical students than would otherwise have seen the article, while also granting us complete control over our message.

Our opposition to Dr Dunjey's submission to Federal Parliament was based on the Marriage Equality and Health policy AMSA passed last year.

Dr Dunjey claimed in an interview with *Australian Doctor* that he was protected by "freedom of speech".

We feel this is not an acceptable excuse for misrepresenting evidence to the Parliament and to the public in support of personal prejudices. It concerns us that this group of doctors invoked their status as our colleagues in an effort to confer credibility on their false claims.

AMSA also made a submission to the inquiry. We made a clear and referenced argument explaining that discrimination is likely to result in "minority stress" and negative mental health sequelae for people who are same-sex attracted. A copy of our policy is available at http://www.amsa.org.au/advocacy/official-policy/

As medical students, we look to doctors as role models, and are disappointed when we see our profession brought into disrepute by prejudicial, much less unethical, behaviour.

The NSW Parliament also recently announced an inquiry into marriage equality. AMSA will submit our policy and supporting research to them, too. We would welcome AMA involvement in our submission.

In the meantime, AMSA's Global Health Officer, James Lawler, and I are travelling to Baltimore in the United States for the International Federation of Medical Students' Association's (IFMSA) General Assembly, and will present an adapted form of our policy there.

It has been co-seconded by the national medical student associations of both the United States and New Zealand.

Since sharing it for review, the emails of support have been pouring in. Recently we have heard from France, the UK, Denmark, Quebec (which is separate to Canada in the IFMSA), plus Brazil and Lebanon.

The only negative feedback so far has come from an office bearer within the IFMSA, who is nervous about upsetting representatives from some of the seven countries who threaten homosexuals with death, or the more than 80 countries who apparently respond with prison sentences.

In countries like Uganda, the extent of the inequitable treatment of people who are lesbian, gay, bisexual, trans or intersex (LGBTI) is astonishing.

A particularly powerful spotlight was thrown on the issue in December 2011 when the then-US Secretary of State, Hillary Clinton, delivered a compelling speech in Geneva, calling for the protection of this "invisible minority".

Many medical students and junior doctors would agree with Ms Clinton that this is "one of the remaining human rights challenges of our time".

Support from senior members of the AMA is welcomed, and helps us to see the relevance and value of membership of a professional association that acts with integrity, compassion and fearlessness.

AMSA would absolutely support prioritising action on these most gross of human rights abuses, and we are hopeful that the IFMSA will adopt our policy, which could lead to opposition to death penalties and custodial sentences for LGBTI people in many countries.

It should be an interesting meeting in Baltimore. What better way to let everyone know how it goes than Facebook?

Or you can follow us on Twitter - @venessb and @yourAMSA

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Welcome move to turn off solariums, but more to be done

BY **PROFESSOR GEOFFREY DOBB**

"There is a need for continuing public education, particularly getting the message through to young people. Doctors, who are well placed to remind patients about the importance of sun-smart behaviour, have an important role to play in this"

Many of you will recall Clare Oliver, the young Victorian woman who spoke publicly about her terminal melanoma diagnosis in 2007 before tragically dying.

Clare's legacy included increasing public awareness about the dangers associated with solarium use.

Melanoma is among the most commonly diagnosed cancers in Australia, and the most common cancer among adolescents and young adults. Research shows that using solariums before the age of 35 years boosts the risk of melanoma by 87 per cent.

At the time that Clare went public with her diagnosis, the AMA developed a policy opposing the use of solariums for cosmetic reasons, and called for increased regulation to ensure young people, and those with certain skin types, be prohibited from using solariums. The AMA also advocated for continuing public education about the dangers associated with any level of solarium use.

Although many jurisdictions responded by tightening restrictions regarding access to solariums, audits found that many operators failed to comply, including a 2011 Victorian study (published by Cancer Council Victoria), which revealed that only 10 per cent of operators were fully compliant.

There was a breakthrough early last year, when the NSW government announced that solariums would be banned from 31 December 2014. The phased approach adopted by the NSW authorities has given time for solarium operators to change the focus of their business.

The NSW announcement was followed by similar measures being undertaken by governments in South Australia, Queensland, and Victoria.

Legislation for a ban is currently before the Tasmanian Parliament and, with an election just around the corner in WA, it would be great to see all major political parties in that state making a commitment on this issue.

Ideally, all Australian jurisdictions should commit to a ban.

In another welcome move, the 2012 Melbourne Fashion Festival, along with leading modelling agencies, banned their models from using solariums.

A spokesperson for Chadwick Models reported that many clients were not after a tanned look. Fashion industry insiders will also know that many wrinkles can be attributed to overexposure to UV radiation, from either the sun or solariums.

Hopefully, young, fashion conscious women will take this cue from the fashion industry and be persuaded of the dangers of tanning.

Research recently released by the Cancer Council (and published in the *Australian and New Zealand Journal of Public Health*), found that while the desirability of a tan is falling among adults and adolescents, one in five adolescents and one in eight adults still report getting sunburnt.

Hat use is decreasing among adolescents, and many people report that they 'stayed in the sun too long', 'forgot to protect themselves' or that the sunscreen 'wore off'.

Recent publications have also highlighted the economic costs associated with skin cancer in Australia. The cost to the nation from non-melanoma skin cancer is predicted to rise from $93.5 million in 2010, to $109.8 million by 2015.

Cases like Clare Oliver's remind us that there is also a very real human cost.

The AMA supports moves to reduce the incidence of all skin cancers in Australia, including a ban on solariums in all jurisdictions. But we can't be complacent.

There is a need for continuing public education, particularly getting the message through to young people. Doctors, who are well placed to remind patients about the importance of sun-smart behaviour, have an important role to play in this.

TO COMMENT CLICK HERE

Working together to ensure Australian doctors are world class

BY **PROFESSOR DAVID WILKINSON, NATIONAL SENIOR TEACHING FELLOW, DEAN OF MEDICINE & HEAD, SCHOOL OF MEDICINE, THE UNIVERSITY OF QUEENSLAND**

As a profession we enjoy significant privilege, and part of our contract with society is that we will ensure that we do the best that we can for our patients. Generally, we do this well, but we need to continually strive to do it better.

Australian medical education, across the spectrum of undergraduate to postgraduate and beyond, is generally recognised to be of very high quality, and we have rigorous quality assurance mechanisms including the accreditation processes of the Australian Medical Council and the oversight provided by the Medical Board of Australia. At the undergraduate level, increased scrutiny is applied by the new Tertiary Education Quality Standards Agency.

At an undergraduate level I think there is, however, a significant gap in our quality assurance framework: we do very little to cross-check the standards applied in our exams at each medical school.

Yes, there are examples of schools collaborating to share exam questions, and yes, there are examples of schools working together to check the performance of students against some common questions, but we don't do this in a structured, comprehensive, or systematic manner. And, because we don't do this, we can't report to our funders and stakeholders, in an explicit and quantitative way, about how students at the various schools perform.

We don't have an explicit standard against which we test, and we don't compare performance of our students or our medical degree programs.

My National Senior Teaching Fellowship is funding me to study global models and to make some recommendations for Australia to consider.

On one extreme of the spectrum is the system in the United States, where every doctor who wants to work there must take the same, standard test – the United States Medical Licensing Exam (USMLE).

This national licensing exam is well entrenched in the US, and the benefits include its very high quality and security of delivery, led by the highly regarded and professional National Board of Medical Examiners. On the flip side, some medical schools don't feel a sense of ownership or commitment to the USMLE.

Medical deans in Australia are not in favour of a medical licensing exam because it risks undermining diversity in medical school curricula and stripping assessment capacity out of medical schools. It would also be very expensive.

At the other end of the spectrum, in the United Kingdom, medical schools work in a formal collaboration to generate exam questions together, share the exams on a secure web site, and collaborate to use this question bank to create "common exams" that allow schools to confirm equivalent performance across their different programs. This seems to be a useful mechanism to provide additional reassurance to the General Medical Council in the UK that schools are performing at an appropriate and an equivalent standard.

National and regional context is all-important, of course; we face very different dynamics in Australia because, for example, we are not part of the European Union, which is exerting a major influence on how the UK develops its quality assurance framework.

But I sense a strong will among medical schools and medical deans to do more to reassure our universities, our governments, the health services that we partner with, and our various funders and interested stakeholders, that we are serious about our responsibilities.

As such, the dialogue is around what to do, and how to do it, rather than whether we should do it.

I think what we (as medical schools) can and should do, is:

- work together in a formal coalition or collaboration;
- share expertise, interest and energy so that we have exam questions that are common or shared;
- each use an agreed number of shared questions, so that we can quantitatively compare performance across schools;
- avoid any risk of league tables by keeping data anonymous, including when we report to the Australian Medical Council for our accreditation; and
- start now, start small, and grow at a pace that suits the sector.

If we keep the goal in mind – ensuring the highest quality of our graduates and hence patient safety – we can avoid traps or counterproductive pathways.

Part of our responsibility as a profession is self-regulation, and my view is that we will provide added reassurance to society if medical schools work together to share exams, and use the information from this to strengthen our programs.

Our patients and our graduates deserve no less.

Support for this article has been provided by the Australian Government Office for Learning and Teaching. The views expressed in this article do not necessarily reflect the views of the Australian Government Office for Learning and Teaching.

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HEALTH ON THE HILL

Footloose miners filling waiting rooms

Fly-in, fly-out workers are placing an enormous strain on health services in rural and remote areas, crowding out the care that can be provided to local residents.

A parliamentary inquiry into fly-in, fly-out (FIFO) work practices has found "considerable evidence" that the rapid growth of transient workforces in remote, resource-rich regions of the country has led to a blow-out in waiting time for treatment and has placed "significant additional workload burdens on doctors".

The report, *Cancer of the bush or salvation of our cities? Fly-in, Fly-out and drive-in, drive-out workforce practices in regional Australia*, said that although there was a lack of robust, empirical evidence, anecdotal reports suggested a significant problem was developing.

In its inquiry, the House of Representatives Standing Committee on Regional Australia heard that in some areas, medical practices had seen a 55 per cent jump in patients coming from out of town since mid-2007.

Many were coming in for medicals, but doctors were also being called out much more frequently to attend accidents and emergencies.

The Committee said that not only did FIFO workforces add to the burden on medical services, they restricted access to services for local residents, and warned that action was needed to address the problem.

"There can be little doubt that continuing to mistakenly assert that non-resident workers do not place pressure on health care and other essential services is dangerous and short-sighted in the extreme," the report said.

The Committee said the difficulty of attracting doctors, nurses and other health staff to work in the bush had spurred the development of FIFO medical services, noting that the 30 per cent of Australians who live in remote and rural areas are served by just 22.4 per cent of the nation's medical practitioners.

Australian Bureau of Statistics figures show that there were 324 medical practitioners for every 100,000 people living in the major cities in 2006, and this ratio plunged to just 136 per 100,000 in remote areas.

While highlighting concerns about the impact of FIFO miners, the enquiry said FIFO arrangements were an important way of delivering health care to remote communities.

The Committee said FIFO medical services were essential for areas where there were simply not enough people to support residential doctors.

"FIFO medical services offer a model of health care delivery, particularly specialist and locum services, to remote communities," it said, noting that in the Northern Territory it was used as a way to provide the full range of health care, including dental and allied health services, to those in the outback.

But the report raised concerns that such services could stunt the development of residential services in areas that warranted them, and had to be properly supported.

"One of the biggest concerns for people in regional areas is that a FIFO health workforce will undermine a residential health workforce and lead to the closure of existing facilities," the Committee said. "In areas that have the population base to support a residential practice, there should be little justification for a FIFO medical workforce."

It said one of the limitations many faced was a lack of appropriate accommodation.

The Committee heard accounts of doctors being forced to sleep in clinic treatment rooms and nurses having to share apartments with strangers.

The report said there was a "significant opportunity" for FIFO medical services to improve health care for those living in rural and remote areas, but only if there was greater national focus on providing the necessary support, including appropriate accommodation, supportive local services, and broadband access, particularly for telehealth and video consultations.

The Committee recommended the Government develop a National Regional Health Plan involving targets and strategies to achieve fair access to health services for rural and remote communities, including through appropriately supported FIFO medical services.

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Nation told to move more, eat better

Australians need to exercise more and make much better food choices if the nation is to avoid a devastating obesity spiral, according to official dietary guidelines.

In a frank call for people to better balance energy input and output, the National Health and Medical Research Council (NHMRC) has recommended that Australians exercise for between 45 minutes and an hour every day – up from the previous 30-minute recommendation – to offset the extra calories people are consuming in their energy-rich diets.

According to the Council, Australians are major consumers of food rich in saturated

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HEALTH ON THE HILL

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fats and sugars with low nutritional value: on average, 41 per cent of the food children consume is junk food, as is 36 per cent of the food eaten by adults.

In its first update to dietary guidelines since 2003, the NHMRC warned there needs to be a major change in eating and exercise patterns if the nation was to bring its obesity epidemic under control, predicting the proportion of men who are overweight or obese would jump to 83 per cent by 2025 – and reach 75 per cent among women - unless habits changed.

The Council said a review of 55,000 peer-reviewed scientific research papers had reinforced existing evidence about what was, and what was not, healthy to eat.

The NHMRC has repeated its call for men to eat less meat, and for all Australians to cut back on white bread, high fat milk, soft drinks, fried and salty foods, take away food, cakes, biscuits, chocolate, confectionary, hot chips and crisps.

Instead, it recommended people eat more vegetables, fruit, low-fat dairy and fish.

Taking a tougher line in its dietary guidelines from 10 years ago, the Council now urges people to "limit" their salt intake (after previously recommending people choose foods low in salt) and to "replace" foods containing saturated fats with those including healthier poly- and mono-unsaturated fats.

NHMRC chief executive officer, Professor Warwick Anderson, said the guidelines had been developed to help health professionals advise patients about their health.

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Boys get protection against HPV

The roll-out of Gardasil vaccination to boys has begun, with more than a quarter of a million due to be inoculated this year.

Health Minister Tanya Plibersek said the vaccine, to be administered free to around 280,000 Year 7 and 9 schoolboys, would help protect them against cancers and genital warts caused by the human papillomavirus (HPV).

The vaccination program for boys, announced in July last year, is a world-first, and comes in addition to a vaccination program for girls which began in 2007.

Ms Plibersek said one million girls aged between 12 and 16 years have already been fully vaccinated against HPV, and the vaccination of boys would help drive down rates of cervical cancer among women.

"The HPV vaccine is the best protection against the HPV virus, [which] infects four out of five sexually active people at some point in their lives, and is linked to cancer and other disease," the Minister said.

Since the introduction of the Gardasil schools vaccination program, there has been a reduction in HPV-related infections and pre-cancerous lesions in young women, and a reduced incidence of genital warts in both sexes.

"We're confident that extending the program to males will reduce HPV-related cancers and disease in the future," Ms Plibersek said.

More than 400,000 boys and girls received their first dose of Gardasil this month, with follow-up doses to be administered in April and August.

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;
- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and 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.

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THE NATION

What is making news in medicine around the country...

VICTORIA

Supervision failure of addicted anaesthetist

A Supreme Court has heard the former Medical Board of Victoria was guilty of "complete incompetence" in failing to prevent a drug-addicted anaesthetist infect 55 women with hepatitis C.

Chief Crown Prosecutor Gavin Silbert told the Court the Board had failed in its duty to ensure James Latham Peters attended and complied with a rehabilitation program for drug-addicted practitioners.

The court heard that Peters, who pleaded guilty to negligently causing serious injury, injected himself with the opioid fentanyl – to which he was addicted – from a syringe.

He then administered, via a cannula, what remained of the drug in the syringe to patients undergoing pregnancy terminations at Croydon Day Surgery.

His committed the offences between June 2008 and November 2009, at a time when he was meant to be working under strict supervision.

The court was told that staff at the Day Surgery failed to exercise "any control" over Mr Peters.

The Medical Board, which had been made aware of Mr Peters' addiction to fentanyl and pethidine in 1996, had originally suspended him while he sought help for his addiction, but allowed him to return to work under supervision.

But the court was told more than 250 drug urine tests that Mr Peters underwent between 2001 and 2009 did not test for fentanyl, and that the Medical Board – which has since been abolished - took Mr Peters' word regarding his attendance at, and compliance with, his drug rehabilitation program.

"The detailed history of the board's dealing with the prisoner reveals complete incompetence in the board's regulation and monitoring of him," Mr Silbert said.

WESTERN AUSTRALIA

Fines for parents who give kids booze

The Western Australian Government has been urged to introduce laws under which parents could be fined for supplying alcohol to children other than their own.

The McCusker Centre for Action on Alcohol and Youth has proposed that WA have secondary supply laws to protect children from the harmful effects of alcohol.

The suggestion was made in a submission to State Government-appointed review of the Liquor Control Act, which is due to report to Racing and Gaming Minister Terry Waldron by 30 June.

Hospital performance in danger

AMA WA President, Dr Richard Choong, has warned the state's hospitals have reached peak efficiency and are unlikely to be able to sustain their nation-leading performance without the commitment of more resources.

An AMA report found that WA hospitals were the only ones in the nation to meet interim National Emergency Access targets last year, with 75 per cent of emergency department cases treated or admitted in four hours or less.

The national rate was 64 per cent.

But Dr Choong said the major parties had been largely silent on health in the lead-up to the State election, and both needed to commit to extra resources for hospitals if they were to sustain their performance.

"Without an increase in the capacity in the system, we're not going anywhere," Dr Choong told the *West Australian*. "What we need to do is increase the number of beds and medical staff within hospitals."

QUEENSLAND

Doctors step into breach

Two specialists have stepped in to fill key vacancies at major Brisbane hospitals following the abrupt departure of senior administrators.

Internal medicine specialist Dr Keshwar Baboolal, formerly consultant urological surgeon in Cardiff, Wales, is the incoming executive director at the Royal Brisbane and Women's Hospital, filling the vacancy left by the departure of psychiatrist Dr David Alcorn.

Meanwhile, cardiologist Dr Darren Walters will succeed Jon Roberts as executive director of Prince Charles Hospital.

Authorities are yet to fill the vacancy left by the departure of Metro North Hospital and Health Service chief executive Keith McNeil.

NEW SOUTH WALES

Cross-border heart help

New South Wales ambulance crews will be able to transmit electrocardiogram results to Canberra Hospital under a potentially life-saving deal struck between the NSW and ACT governments.

Under the agreement, NSW ambulance crews treating heart attack patients in areas near the ACT will be able to have vital information about heart function quickly transmitted and assessed at Canberra Hospital, enabling quick and effective decision to be made about treatment.

The initiative is the latest in a series of cross-border arrangements intended to enhance the quality of health services available to patients in rural NSW areas surrounding the ACT.

These include the joint operation of renal services by the ACT Health Directorate and the Southern NSW Local Health District and the provision of emergency medicine training by ACT specialists to rural NSW hospitals.

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Research

Real dangers from artificial high

Researchers have found synthetic marijuana can cause kidney damage in teenagers and young adults.

More than fifteen people who smoked synthetic marijuana were hospitalised with kidney problems last year in the US, the researchers found, with five requiring on-going dialysis.

Synthetic marijuana is plant material that, once sprayed with certain chemicals, can mimic the euphoric effects gained from using marijuana. It has been tied to a number of health problems including rapid heartbeats and seizures, though this is the first time it has been connected to kidney problems.

Lead researcher, Assistant Professor Gustav Jain from the University of Alabama, said cases of acute coronary syndrome associated with synthetic marijuana use have been reported, but this is the first publication to associate use with acute kidney injury.

He said that nephrotoxicity – the poisonous effect of a substance on the kidneys – from designer drugs such as SPICE or K2, which mimic the effects of marijuana but are man-made and cannot be detected in routine drug tests, should be considered when a patient presents with acute kidney injury and no other evident cause

"There is very little information regarding the ingredients in synthetic cannabinoids that are sold on the streets, although it is known that additional compounds are added to the preparations," Assistant Professor Jain said.

"It is very likely that a possible nephrotoxin adulterated the preparation used by the patients.

"If they don't get to a physician in time, damage to their kidneys could be permanent, and they could end up on dialysis."

The American Centers for Disease Control and Prevention said it was not known exactly what caused the kidney damage in the subjects identified in the research.

Several American federal and state laws ban some of the chemicals used in the production of synthetic marijuana.

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Older dads a greater health risk for kids

Older fathers have a greatly enhanced risk of having autistic children or producing a foetus that miscarries, indicative research shows.

World-leading reproductive biologist Professor Robert Norman, from Adelaide University's Robinson Institute, told a Health-Science Alliance meeting that a father's age, health and lifestyle can have life-long affects on the health of their offspring.

"It's early days, but our research and others, looking at 92,000 men, shows that a man who is aged more than 40 whose sperm creates a pregnancy, increases the risk of a miscarriage at least six times, and is six times more likely to have an autistic child," Professor Norman said. "The bottom line is that advancing parental age can be problematic."

He said the challenge was to use existing knowledge and the results of future research to inform parents-to-be, and offer them tests that can reduce the risk of problems in their offspring.

"We think, for example, sperm testing has the potential to show prospective fathers – especially older ones – whether they are more likely to produce offspring with problems such as autism," Professor Norman said.

But separate research has highlighted the ability of mothers to greatly reduce the chances of their offspring developing autism by taking folic acid.

A study of 85,000 Norwegian children, published in the *Journal of the American Medical Association*, found that mothers who took folic acid during pregnancy cut the likelihood that their child would develop autism by 39 per cent.

To prevent spina bifida and autism, folic acid should be taken in the month before a woman becomes pregnant, and through the first trimester of pregnancy.

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Research

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AMA President, Dr Steve Hambleton, told the *Daily Telegraph* the findings were "another reason we should remind women to prepare for pregnancy".

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Traitorous brains inhibit fight against flab

Researchers have pinpointed a circuit in the brain that hampers the ability of people to lose weight, holding out the promise of of more effective ways to tackle obesity.

In an important advance in understanding how the body regulates energy use and weight loss, scientists at Sydney's Garvan Institute of Medical Research have shown that the neurotransmitter Neuropeptide Y (NPY) plays a major role in controlling the use of energy.

The researchers, led by Dr Shu Lin, Dr Yanchuan Shi and Professor Herbert Herzog, found that NPY, produced in the hypothalamus, inhibits the activation of brown fat (brown adipose tissue), one of the primary heat-generating tissues in the body.

Professor Herzog said the study, published in *Cell Metabolism*, was the first to identify the neurotransmitters and neural pathways that carry signals generated by NPY in the brain to brown fat cells throughout the body – telling them whether to burn or conserve energy.

"When you don't eat, or dramatically curtail your calorie intake, levels of NPY rise sharply," Professor Herzog said. "High levels of NPY signal to the body that it is in starvation mode, and should try to conserve as much energy as possible."

He said the human body had developed these mechanisms to survive periods of famine, and were strictly controlled.

"When people had to survive by finding food or hunting game, they could not afford to run out of energy and die of exhaustion, so their bodies evolved to cope.

"Until the twentieth century, there were no fast food chains and people did not have ready access to high fat, high sugar foods.

"So, in evolutionary terms, it was unlikely that people were going to get very fat, and mechanisms were only put in place to prevent you losing weight.

"The challenge will be to find ways of tricking the body into losing weight, and that will mean somehow circumventing or manipulating this NPY circuit, probably with drugs."

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INFORMATION FOR MEMBERS

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

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

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

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

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Hundreds die as budget targets come before patient care

"You cannot run a hospital like a supermarket or warehouse … Just-in-time delivery does not work in medical care.""

Investigations have been launched into the management of more than a dozen major British hospitals following the revelation that hundreds of patients at Stafford Hospital died unnecessarily because of negligence, misplaced priorities and systemic failure.

In a tragedy that AMA President, Dr Steve Hambleton, said held important lessons for how Australian hospitals were managed, a damning report found that between 400 and 1200 patients died at the UK hospital between 2005 and 2008 because of neglect and cost-cutting driven by a management culture that put meeting budget and performance targets ahead of caring for patients.

In addition to premature deaths, the report into what has been dubbed the Mid Staffs scandal found many patients suffered in appalling conditions, including being forced to soil their beds because there was no staff available to take them to the toilet, going without meals for extended periods and having to resort to drinking water from vases because of inadequate nursing care.

In his report, released earlier this month, inquiry head Robert Francis condemned what he described as a "serious failure" of the hospital Board in its oversight and management, and a breakdown in the system of checks and balances within the National Health Service (NHS) intended to detect and prevent such shortcomings in care.

Mr Francis said the hospital's Board and senior managers had lost sight of their overriding goal – patient care – and warned that across the NHS system a "fundamental culture change is needed… to put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it".

It was a finding echoed by Dr Heather Wood who, as the author of a Healthcare Commission report into Mid Staffordshire NHS in 2009, first broke the scandal.

In an article in the *British Medical Journal* on 6 February, Dr Wood said the entire NHS management was infected by a culture in which meeting budget and performance targets was given priority over patient care.

She said the effect of this was exacerbated by arrangements in which clinicians were sidelined from hospital management.

"All the failings at Mid Staffs derived from the handing of control of decisions on priorities from the clinical professions to managers who were ultimately expected to follow the orders of senior managers," Dr Woods wrote. "Those giving the orders often ignore or fail to understand the complexities of clinical care, the constraints on the NHS, and the impact of one policy on another component of care."

Dr Woods said that in other British hospitals, in Maidstone and Tunbridge Wells, the pursuit of financial and waiting time targets "directly affected" the focus on infection control.

"Concerned doctors and nurses were pilloried; patients were not adequately isolated; and cleaning was not thorough enough," she said, leading to serious, fatal outbreaks of *Clostridium difficile*.

AMA President, Dr Steve Hambleton, said the Mid Staffs scandal highlighted how quickly and disastrously things could go wrong when the focus of health services was on financial performance instead of patient.

Dr Hambleton said providing health care was not the same as operating a business.

"You cannot run a hospital like a supermarket or warehouse," he said. "Just-in-time delivery does not work in medical care."

"This is a timely warning for all governments thinking about hospital management practices," Dr Hambleton said. "The patient is the primary client, not the payer."

The AMA President said the Mid Staffs scandal showed why it was so important that medical practitioners be involved in the management and governance of hospitals.

"The AMA's long-standing position is that you have got to get medical practitioners back involved in hospital management and governance," Dr Hambleton said. "Lead clinician groups have to be about more than just standards. They have to be involved in decisions about how hospitals are run, how money is spent."

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Kiwis to snub out fancy tobacco packaging

New Zealand has moved to join Australia in forcing tobacco companies to sell their products in plain packaging.

New Zealand's Associate Health Minister, Tariana Turia, announced last week that legislation to enforce plain packaging for cigarettes and other tobacco products would be introduced by the end of the year.

"Currently, the packaging does everything it can to attract consumers and increase the perceived appeal and acceptability of smoking," Mrs Turia told *news.com.au*. "The bright colours and other design elements divert people's attention away from the health warnings which tell the truth about just how deathly dangerous smoking is."

Under the proposed laws, the colour and design of cigarette and other tobacco packaging would be regulated to maximise the impact of the health warnings, and tobacco brand names would be printed in standardised fonts and sizes.

"The move to plain packaging would make more explicit what tobacco is - a product that kills 5000 New Zealanders a year," the Minister said.

Last year the Australian Government became the first in the world to introduce plain packaging laws, successfully fending off a legal challenge from the major tobacco companies in the High Court.

Australia still faces action launched by a number of tobacco exporting countries under the auspices of the World Trade Organization.

Though the New Zealand Government expects its plain packaging legislation to be supported by most political parties, it anticipates it will be challenged in the courts by the tobacco companies, and has been advised the cost of defending the action could reach almost $5 million.

Australian Health Minister Tanya Plibersek and Attorney General Mark Dreyfus hailed the New Zealand Government's move.

"We are absolutely delighted the New Zealand Government has joined Australia in putting the health and welfare of its citizens ahead of profits for Big Tobacco," Ms Plibersek said.

Mr Dreyfus said Australia would "vigorously defend" its plain packaging laws at the WTO "or in any other forum where they may be contested".

Chair of Cancer Council Australia's Tobacco Issues Committee, Kylie Lindorff, said early evidence suggested Australia's plain packaging laws were being very effective in discouraging smoking.

"In the two-and-a-half months since the laws [came into effect]… calls to the Quitline [have] increased significantly, and we've also heard anecdotal reports of smokers mistakenly thinking the content of cigarettes has changed," Ms Lindorff said.

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INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

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Dexter wines shine

BY **DR MICHAEL RYAN**

"These well-drained soils are somewhat thin, which helps temper the growth of the vines. It is always said a vine that struggles produces more intense fruit"

We are truly blessed with wine in Australia.

The ability to ripen fruit, combined with the masterstrokes from the wine maker melding art, science and intuition, result in world-class wines.

Todd Dexter, from the Mornington Peninsula, is one such vigneron who is focused on creating elegant wines. He coaxes the finicky grape that is Pinot Noir out of its pre-pubescent shell and dollies up the "work horse" grape Chardonnay and makes it the belle of the ball.

Todd had great exposure to wine through his family's enthusiasm for the noble drink, but was also aided by ties with the Crittenden family - well known in Victoria's wine circles.

A seven-year stint at Cakebread Cellars in California's world-renowned Napa Valley honed his winemaking skills, and in 1987 he and his wife Debbie purchased a vineyard site in Mornington Peninsula, which was leased to Stonier wines.

He was integral to the expansion of Stonier wines over the following decade. Yabby Lake, another prestigious winery, also blossomed with help from Todd's winemaking prowess.

His respect for terroir was enhanced with a stint in France in 2002 and, following this experience, he decided to found his own Mornington Peninsula label, with wines from his own vineyard.

He chose as his site a piece of land along Foxeys Road in Merricks North, planting on north-facing slopes with the vines oriented east-west to extract maximum warmth from a potentially cool climate.

These well-drained soils are somewhat thin, which helps temper the growth of the vines. It is always said a vine that struggles produces more intense fruit.

The quality of the fruit has been attested to by the fact that a substantial amount of it has been used in the Stonier Reserve Pinot Noir. About seven hectares are evenly planted to Chardonnay and Pinot Noir.

Wines Tasted

2011 Dexter Mornington Peninsula Chardonnay

Handpicked and whole bunch pressed is indicative of Todd's attention to detail. Natural yeast inoculation and 23 per cent new French oak were used in the fermentation process, with 75 per cent of the wine undergoing MaloLactic fermentation. The colour is pale straw, with hints of green. The nose has classic Chardonnay aromas of white peach and lemon, with overtones of nectarines. Spicy, nutty notes with floral nuances make the bouquet alluring. The palate is full in nature, with restrained fruit enhanced by good acid structure. The fine French oak influence makes this a beacon of light in a world of overdone or astringent Chardonnay. Try with anchovies and creamy fetta on bruschetta.

2010 Dexter Mornington Peninsula Pinot Noir

Another handpicked selection of fruit taken off the stem. There is a mixture of wild and cultured yeasts. Twenty-five per cent new French oak is used, and the wine was bottled after 10 months. The colour is a pale garnet. The nose displays sensual fruit notes of cherries, some darker fruits and hints of woody spices. An earthiness develops as the wine opens up. Importantly, this rich elegant fruit bouquet is transformed on the palate as a silky mouth-smacking ride. Fine tannins and acidity balance out to leave a lingering finish. Try with smoked turkey terrine, both served slightly chilled.

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