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Anti-vax groups put kids at risk

Time for crackdown on misleading claims, p6

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Don't bury McKeon

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

"Australia has a proud track record of producing some of the world's outstanding researchers, some of whom are household names"

The Strategic Report on Health and Medical Research was released by the Federal Government earlier this month.

The Review was chaired by Simon McKeon, Chairman of the Board of the CSIRO and 2011 Australian of the Year, and the five others who were with him on the Panel made up an outstanding team.

They and the members of their Secretariat completed a huge amount of work, and those involved in the Australian medical research community had no shortage of opportunities to provide input – input that has been integrated into a final report, providing a coherent 10-year strategy for health and medical research in Australia.

Australia has a proud track record of producing some of the world's outstanding researchers, some of whom are household names.

Yet the release of the report created scarcely a ripple of media interest, despite its potential to affect our future health and a large sector of the economy.

A dollar invested in medical research has been conservatively estimated to return $2.17 in health benefits. The payback from some research has been far greater.

As Mr McKeon points out, current increases in health expenditure are not sustainable. With so much of health care costs relating to personal services – medical, nursing, allied health – the key is to keep people healthier for longer, and who doesn't want that? With it comes the potential to increase economic productivity.

Other potential economic benefits could come from a listed biotechnology sector worth over $60 billion, delivering increased pharmaceutical exports and the creation of more than 80,000 jobs in biotechnology industries. But this won't happen without investment.

A recent survey by Research Australia found 91 per cent of Australians believe improving hospitals and the health system should be the highest priority for the Government, and 80 per cent listed increased funding for health and medical research as among the highest priorities for Government, ranking it ninth on the list of priorities.

The McKeon Review made many recommendations, each supported by compelling evidence. These included:

- embedding research in the health system, with increased funding of between $1 to $1.5 billion a year, with a research and development investment target of between 3 and 4 per cent of total Government health expenditure;
- the establishment of 10 to 20 integrated health research centres;
- the provision of up to 1000 research fellowships;
- streamlining clinical trial processes, building on the recommendations of the Clinical Trials Action Group;
- supporting a range of strategic topics and priorities;
- providing support for commercial development; and
- increase efforts to attract philanthropic support.

The key to the strategy is investment.

Current public sector investment is well behind the McKeon target.

The Independent Hospital Pricing Authority has suggested that public hospital support for teaching, training and research is between 3.5 and 5 per cent of total expenditure, leaving a large gap to make up from public funding.

The Review also highlights the risks of not investing in research. The most important of these would be failure to embed research in the health system, such that work to translate research with benefits for the future is squeezed out by the imperative to deliver clinical services today – a risk that will resonate with all currently working in health care.

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Education expense cap to put lives, quality health care at risk

The Federal Government has been warned it risks putting lives in jeopardy and compromising the quality of health care by forcing doctors to shoulder a sharp increase in education expenses.

AMA President Dr Steve Hambleton has written to Treasurer Wayne Swan to protest against the Government's unheralded decision to cap tax deductions for work-related self-education expenses at $2000 a year, arguing the move creates a "huge disincentive" for doctors to undertake the continuous education needed to maintain their qualifications, upgrade skills and learn about advances in patient care and treatment.

Late last week senior AMA officials met with representatives from the Treasurer's office to directly raise concerns about the proposed tax changes. The Government officials gave assurances that they did not want to disadvantage genuine professional development activities.

Dr Hambleton said doctors typically spend much more than $2000 each year to attend courses, workshops and conferences in order to meet continuing professional development requirements as well as to enhance their knowledge and skills, with patients the ultimate beneficiaries through access to world-class quality care.

"Australia has some of the most demanding medical training courses in the world, and the Medical Board of Australia and the Medical Colleges require doctors to maintain their skills through continuing professional development," the AMA President said. "The costs of education and training required to comply with these regimes are significant, and generally well above $2000 per annum."

> "It will create a huge disincentive for doctors to pursue specialised education that could help save lives and improve the quality of life for many Australians"

For example, he told Mr Swan, the Australian and New Zealand Surgical Skills Education and Training program costs $3280, the fee for the Care of the Critically Ill Surgical Patient course is $2735, while a GP attending Clinical Emergency Management Program workshops can face combined costs above $3000.

"These types of courses equip doctors with essential skills in caring for patients, yet on the Government's approach appear to be regarded as excessive," Dr Hambleton said.

The Treasurer announced the clampdown on self-education expenses as part of savings to help pay for its ambitious $14.5 billion Gonski schools reform package.

It also came as the Government is scrambling to identify savings ahead of next month's Budget, which is seen as crucial to any hope Labor may have of being re-elected on 14 September.

Mr Swan officially abandoned Labor's pledge to deliver a Budget surplus this financial year, but is under pressure to map out a credible path to a return to surplus as soon as possible.

The Treasurer said the self-education tax deduction changes, due to come into force from 1 July 2014, would save about $520 million over the forward estimates, and had been carefully designed to only target excessive claims.

Mr Swan said that although the Government valued the investment people made in their own education, "under current arrangements these deductions are unlimited, and provide an opportunity for people to enjoy significant private benefits at taxpayers' expense".

"Without a cap on the amount that can be claimed as a deduction, it's possible to make large claims for expenses such as first class air fares, five star accommodation and expensive courses," the Treasurer said.

But Dr Hambleton dismissed the idea that doctors were claiming excessive tax deductions for their education costs.

He said medical training courses did not come cheap, and many doctors – particularly in rural areas – had little option but to travel, either within Australia or overseas, to learn about the latest medical research, leading-edge surgical techniques and advances in overall patient care.

Chair of the AMA Rural Medical Committee Dr David Rivett warned the $2000 cap on tax deductions for education expenses would hit country doctors particularly hard.

"I try and attend at least three training courses annually, for up to four days each, plus travel days, as I am sure many rural GPs do in the best interests of their patients," Dr Rivett said. "For example, I

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Education expense cap to put lives, quality health care at risk

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am attending an anaesthetic conference in Melbourne in a couple of weeks. With registration, some hands-on sessions, airfares, accommodation and meals, the cost will run to well over $4000.

"More isolated practitioners would face even greater costs, as travel times and airfares would zoom up much higher.

"It makes the rural training subsidy of $2000 a day for up to four days a year worth very little if costs become non-deductible.

"[The proposed change is] not conducive to ongoing learning and the provision of quality patient care."

Dr Hambleton has sought an urgent meeting with Mr Swan to discuss changes to the reform "so that it does not unfairly impact on doctors and standards of patient care".

"The Government's reform will hit junior doctors, salaried doctors, GPs and other specialists, and patients, and is simply not in the public interest," the AMA President said.

"While the AMA recognises the need to ensure claims for self-education expenses are not out of step with community standards, the one size fits all approach adopted by the Government simply ignores the high costs of medical training and education.

"It will create a huge disincentive for doctors to pursue specialised education that could help save lives and improve the quality of life for many Australians."

The Australian Dental Association has added its voice to the protest, arguing that the Government was ignoring the fact that training was compulsory and helped protect patients.

The Government said the fringe benefits tax exemption for employers providing education and training for their employees would be retained.

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Don't bury McKeon ...CONTINUED FROM PAGE 3

A risk those on the Review did not foresee was the recently announced cuts to university funding, allegedly to finance school education. The effect of these cuts is still unknown, but anything that weakens the already tenuous career pathway of researchers will undermine medical research.

Another threat was outlined in *The Australian Financial Review* on 11 April, in which it reported that Australia's independent medical research institutes were facing a $70 million black hole because of changes to their funding. This will also seriously affect their cash flow.

This comes on top of flat National Health and Medical Research Council funding in the last four to five years. The response of an unidentified NHMRC spokesperson to these concerns was straight from the *Yes Minister* script, declining to comment on whether a cut to Council's $746 million 2011-12 allocation was expected in next month's Budget.

We know there is huge support from Australians for medical research through their donations, both large and small, to charities.

The last time cuts to medical research funding were threatened, an upswell of public opinion in opposition was probably instrumental in ensuring the sector was relatively protected.

The AMA has strongly supported growth in medical research funding in our Budget submission.

With an election in the offing, we will be calling on all political parties to publicly adopt the recommendations of the McKeon Review. Without that support, these initiatives risk being stillborn.

Coalition health spokesman Peter Dutton welcomed the release of the McKeon Review, and guaranteed continuity of funding for medical research. Opposition leader Tony Abbott has made a similar commitment, and stated that medical research was envisaged by the Coalition to be part of its 'Education and Research' pillar, an essential part of the Coalition's plan "to build a more diverse, world class five-pillar economy". But these comments still fall short of adopting McKeon's recommendations.

If the McKeon report is ignored and left to gather dust, Australia's health and financial future will be so much poorer than it could have been. It would be a great opportunity missed.

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Anti-vax parents failing in responsibility to all

AMA President Dr Steve Hambleton has called for tougher action against groups making misleading claims about the dangers of vaccination amid evidence that thousands of children are being left vulnerable to deadly diseases.

Speaking as official figures were released showing that almost 80,000 children were not immunised, including significant pockets of vulnerability to measles, whooping cough and other diseases around the country, Dr Hambleton urged a crackdown on misleading claims by anti-vaccination campaigners and action to get the parents of unvaccinated children to reconsider their position.

"As parents, we have a responsibility to our children [and] we have a responsibility to other children in the community," the AMA President said. "We should certainly make it difficult for [unvaccinated] children to get to school, and we should certainly have plans to send all those children home if there are outbreaks."

Dr Hambleton said it was too soon to consider banning unvaccinated children from school, preferring that greater effort be devoted to educating parents about the importance of immunisation.

"But we should make it difficult for parents [of children who have not been immunised], so they do have to think twice about whether they vaccinate their children," he said.

Dr Hambleton's call was backed by several current and former school principals and senior staff who expressed frustration that parents who conscientiously objected to the vaccination of their children were potentially compromising the health of all.

Figures compiled by the National Health Performance Authority (NHPA) show that almost 77,000 children nationwide were not fully immunised in 2011-12.

What has particularly worried disease control experts is that there are substantial variations in the level of child immunity by age and location.

The report, which provided a detailed three-tier breakdown of immunisation rates by Medicare Local catchment, statistical area and postcode, highlighted several pockets - including in eastern Sydney, inner and northern Perth, Fremantle, the Sunshine Coast, New England and North Coast NSW - where vaccination levels were dangerously low, exposing children to potentially deadly outbreaks of measles, whooping cough and other serious infections.

Dr Hambleton said that in order to prevent diseases spreading, at least 93 per cent of children in any one area had to be vaccinated, but among five-year-olds "we're nowhere near 93 per cent in [23 of 61 Medicare Local catchments], which is really disturbing".

The NHPA has identified 32 statistical areas [out of 325 nationwide] where children who had not been immunised were most at risk of being infected by serious illness including measles and whooping cough.

"In these areas, the percentages of children fully immunised were 85 per cent or less in at least one of the three age groups [one year, two years and five years]," the Authority said.

While immunisation rates were low in several remote areas with significant Indigenous populations, the figures showed that children in some affluent coastal and inner urban suburbs were also being left vulnerable to serious disease because of low levels of vaccination.

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Anti-vax parents failing in responsibility to all

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Manly, Mosman, inner west Sydney, Byron Bay, Lennox Heads, the Blue Mountains, Kempsey and Nambucca were among several areas in NSW identified by NHPA as being at risk of outbreaks because of low vaccination rates, as were parts of central and eastern Perth, the Sunshine Coast, Fremantle, and north-west Victoria.

Dr Hambleton said anti-vaccination activists had been particularly active in northern NSW and south-east Queensland, where there were pockets of low immunisation. Not coincidentally, he said, these were areas that had also suffered recent measles outbreaks.

"Generally measles comes in from overseas, but it won't spread unless there's a susceptible population, and in both those areas there is a susceptible population and there are anti-vaccination networks active," the AMA President said.

Dr Hambleton said anti-vaccination groups should be punished for misleading people about the benefits and dangers of vaccination.

"They are putting the community in danger. They should be ashamed of themselves," he said. "We should stop pretending they're spreading balanced information when they're not. There should be some sanction for spreading misinformation."

In NSW the so-called Australian Vaccination Network, which campaigns against vaccination, is fighting a rearguard legal action in the Administrative Decisions Tribunal against an order by NSW Fair Trading that it change its name or face deregistration.

Dr Hambleton said efforts to boost vaccination rates were also being hampered by the Government's decision in last year's Budget to axe funding which had supported GPs in tracking child vaccinations.

> "We're very concerned that this is the first time we're seeing evidence that in pockets there is insufficient vaccination to prevent those very serious diseases from spreading"

In a move that was expected to cost some practitioners up to $4500, as well as undermining an important preventive health measure, the Government scrapped the GP Immunisation Incentives Scheme, under which doctors received incentive payments for ensuring more than 90 per cent of their child patients were fully immunised.

"We did warn the Government when they withdrew funding for GPs for that payment for completed vaccination, that this is one of the legs of the tripod to maintain our high vaccination rates," Dr Hambleton said. "We're very concerned that this is the first time we're seeing evidence that in pockets there is insufficient vaccination to prevent those very serious diseases from spreading."

In addition to significant under-vaccination in some areas, the AHPA report showed that vaccination rates fell away as children got older.

In more than a third of the nation's 61 Medicare Local catchment areas, less than 90 per cent of five-year-olds were fully immunised, whereas among one-year-olds this was the case in only two Medicare Local catchment areas, and for two-year-olds there were just three catchment areas where their immunisation rate was less than 90 per cent.

Dr Hambleton said there were many reasons why parents failed to keep the immunisation of their children up to date, including conscientious objections to vaccination, changing address, losing track of documentation and losing touch with their family doctor.

He said that although the AHPA data did not show why children were not being vaccinated, it did indicate the areas where efforts to boost vaccination rates needed to be intensified.

"[With] this data we can actually track where those parents are living, and we need to provide them with information to make sure we're actually doing our bit to get those immunisation rates up," the AMA President said, adding that GPs were central to the effort.

"The best place immunisation can be done is with your family doctor, because we keep all the information in one place, we make sure we have a complete record, we avoid fragmentation, and it's the family doctor that can actually forward that information back on to the Australian Childhood Immunisation Register."

While the Federal Government has axed the immunisation incentive payment for GPs, it has linked eligibility for some family payments to vaccination.

To be eligible for the $726 Family Tax Benefit Part A supplement, parents are required to ensure that their children are fully immunised.

A booklet setting out the facts and myths regarding vaccination, *The Science of Immunisation: Questions and Answers*, has been produced by The Australian Academy of Science, and is available free of charge at: www.science.org.au/immunisation.html

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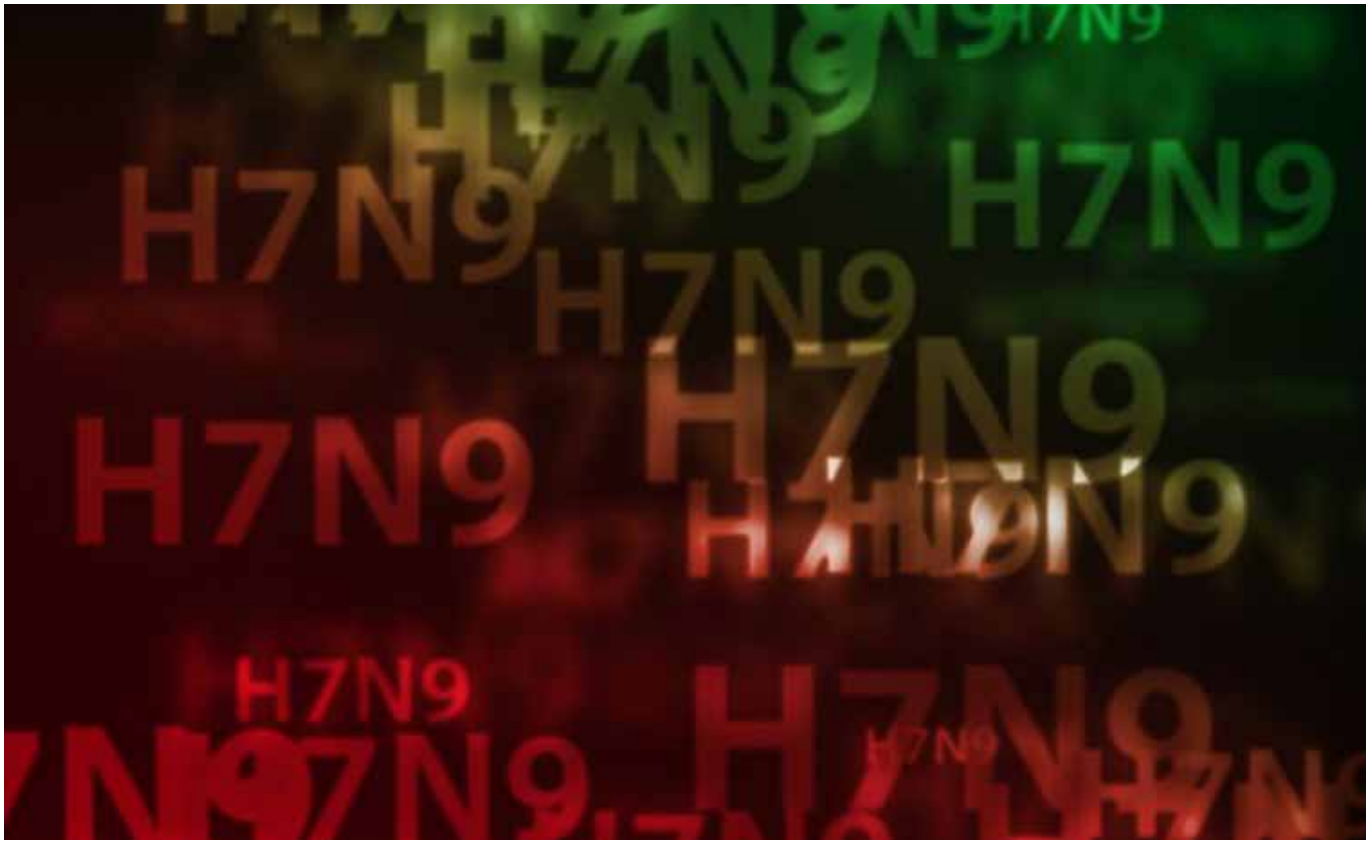
Fears deadly bird flu may be spreading between people



Chinese authorities are investigating possible human-to-human transmission of a deadly new strain of bird flu in what could be an ominous development in an outbreak that has claimed more than a dozen lives and infected more than 80 people.

Late last week the World Health Organisation said that there was as yet "no evidence of ongoing human-to-human transmission" of the avian influenza A (H7N9) virus, but a senior Chinese health official said investigations were being made into possible "family clusters" of the infection.

Director of the Health Emergency Centre at the Chinese Centre for Disease Control and Prevention Feng Zijian indicated authorities were "paying close attention" to instances of infection within one family.

According to Reuters, Mr Feng said "we are still analysing in-depth to see which has the greatest possibility – did it occur first from avian-to-human transmission, and then a human-to-human infection, whether they had a common history of exposure, were exposed to infected objects, or whether it was caused by the environment".

The investigations include a father and two sons who have all died after being infected with the virus.

As at 18 April, 18 people had died from the infection, while the total number of laboratory-confirmed cases had climbed to 82.

Most of the human H7N9 cases have occurred in Shanghai or the surrounding region, though there have been two confirmed infections in Beijing, more than 1000 kilometres to Shanghai's north.

Attempts to control the outbreak have been frustrated by problems in identifying the source, because so far birds carrying the H7N9 virus have not displayed symptoms.

The WHO said that the health of more than a thousand people who have been in close contact with infected humans is being closely monitored, and it warned the virus was likely to claim more victims.

"Until the source of the infection has been identified, it is expected that there will be further cases of human infection with the virus in China," the WHO said.

Despite this, it did not think there was a need for special screening at Chinese airports and other points of entry, and did not recommend any travel restrictions.

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Inside Australia's response to Chinese bird flu outbreak

"I am confident that Australian health authorities and our health care professionals are well situated to deal with any new and emerging threats"

When news about the new H7N9 influenza virus broke, Australian health authorities responded quickly under the direction of the Commonwealth Chief Medical Officer, Professor Chris Baggoley.

The Office of Health Protection, within the Department of Health and Ageing, immediately linked in with the World Health Organisation to ensure Australia had the most current information available, and to gain access to the virus for diagnostic testing and potential vaccine development.

Infections due to H7N9 are currently present in six regions of the Chinese mainland, which represents possible spread of the outbreak towards the north and west.

All cases, with the exception of those identified in Beijing, have occurred in contiguous provinces. The source of infection remains unclear. No epidemiological links have been found, however concern remains about the potential for the virus to spread between people.

Professor Baggoley said that Australia has been impressed by China's openness and willingness to share information with health authorities around the world and, while there is still no evidence of sustained human to human transmission, the Office of Health Protection is closely engaged with key public health and scientific experts to ensure that all the systems are in place to respond to this public health issue should it escalate.

Professor Baggoley has convened a meeting of the Australian Health Protection Principal Committee (AHPPC), the peak health emergency management body which comprises all State and Territory Chief Health Officers, and a range of other public health experts, to review the country's preparedness for a potential national response.

One of the AHPPC's first actions was to develop guidance for primary care providers, and earlier this month Professor Baggoley issued information for practitioners in general practice, hospitals and laboratories on how to detect the virus in patients who present for treatment, including guidance on diagnostic testing, investigation and infection control.

The Office of Health Protection has also been in liaison with the Public Health Laboratory Network, Communicable Diseases Network Australia, the WHO Collaborating Centre for Reference and Research on Influenza and other public health experts to ensure the virus can be readily isolated in a laboratory setting.

For the information of the public and health professionals, the website www.health.gov.au provides a link to comprehensive information about the current situation and is updated daily.

"Building on the success and lessons learned from the national response to SARS and the 2009 influenza pandemic, I am confident that Australian health authorities and our health care professionals are well situated to deal with any new and emerging threats," Professor Baggoley said.

** Information provided by the Department of Health and Ageing*

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Force feeding, torture not part of medical script

Doctors should refuse to force feed hunger-striking prisoners and detainees against their will, and should only treat restrained inmates where there is an immediate risk of harm, the AMA has said.

As almost 30 refugees at the Melbourne Immigration Transit Accommodation centre in Broadmeadows hold a hunger strike to protest lengthy delays in releasing them into the community, the AMA has released guidelines suggesting medical practitioners respect the right of competent adults to refuse nourishment.

"Where a prisoner or detainee refuses nourishment and is considered by the doctor to be capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, the doctor should refuse to cooperate in artificial feeding," the *AMA Position Statement on Medical Ethics in Custodial Settings* said. "Forced feeding contrary to an informed and voluntary refusal is not justifiable."

Though there is no indication yet of moves to force the refugees - many of them of Tamil descent who have been detained because of adverse security assessments despite recognition of their refugee status - to eat, there are concerns doctors could be thrust into an ethically challenging position if authorities try to end the protest by force feeding.

The Association advised that doctors should not apply "undue pressure" on hunger strikers to end their protest, such as by threatening to withhold treatment unless the hunger strike ends, but should meet with protesters daily to check their willingness to continue the protest and clarify the wishes of each hunger striker in the event that they lose decision-making capacity.

AMA President Dr Steve Hambleton said the fundamental role of medical practitioners was to alleviate distress, and prisoners and detainees needed to be treated with respect and dignity, and be accorded the same right to humane treatment as the rest of the community.

Dr Hambleton said doctors should refuse to allow their clinical role to be compromised by the demands of others, including governments.

"Medical practitioners must have complete clinical independence in deciding upon the care of a prisoner or detainee for whom he or she is medically responsible," the AMA President said. "The doctor's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive – whether personal, collective or political – should prevail against this role."

The advice comes against the backdrop of the widespread intimidation, harassment and arrest of hundreds of doctors and other health workers in Syria, Bahrain and a number of other countries in an attempt to deny treatment to those injured in war or civil unrest.

At its Council meeting in Bali earlier this month, the World Medical Association condemned attempts by governments to control how doctors practised medicine, citing as an example the 400 physicians arrested in Syria for providing care for the injured, regardless of their political affiliations in that country's civil war.

In its Position Statement, the AMA provided advice for medical practitioners regarding a number of challenging situations and demands they might face in caring for prisoners or detainees.

It advised doctors that they should not assist in body cavity searches conducted solely for the purpose of obtaining evidence or retrieving substances and, where they were undertaken for medical purposes, they should be undertaken by a doctor from outside the correctional facility.

In its guidelines, the AMA voiced its strong objection to solitary confinement, which it condemned as an inhumane method of punishment, and admonished practitioners not to participate in degrading or inhumane treatment.

"Doctors must not countenance, condone, or participate in the practice of torture or other forms of cruel, inhumane or degrading procedures," the Position Statement said, and "should not use, or allow to be used, medical knowledge or skills specific to an individual to facilitate or aid an interrogation."

Related to this, the AMA said doctors should not assist in the restraint of inmates for non-medical purposes, advising that "medical personnel should never proceed with medical acts on restrained people, except for those with potential for immediate and serious risk for themselves and others".

In treating prisoners and detainees, the AMA said such inmates should be accorded the dignity and respect due to patients in the broader community, including keeping any health information confidential, except where there are legal requirements or the risk of serious harm to others.

It advised non-treating doctors brought in to provide medical assessments for judicial, evidentiary or security purposes that they must ensure prisoners understand the purpose of the examination and consent to it, before proceeding.

A copy of the Position Statement can be viewed at: http://ama.com.au/position-statement/medical-ethics-custodial-settings-2013

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UK hospital scandal highlights role of doctors in ensuring safe, quality care

"Quality and safety systems within hospitals should harness medical practitioners' continuous motivation to improve"

A United Kingdom hospital scandal in which hundreds of patients died unnecessarily because of negligence, misplaced priorities and systemic failure has underlined AMA calls for doctors to be directly engaged in ensuring the safety and quality of care.

Britain's National Health Service (NHS) is still reeling from revelations that up to 1200 patients at Stafford Hospital died 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.

A damning report found there had been a "serious failure" by the hospital Board in its oversight and management, and Dr Heather Wood – who broke news of the scandal – warned the entire NHS management was infected by a culture in which meeting budget and performance targets was given priority over patient care, and 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 in the *British Medical Journal* on 6 February.

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

The AMA President said it 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, particularly regarding quality and safety systems.

"It is vital that clinicians are involved in the development, implementation and maintenance of these systems," the AMA President said.

In its Position Statement on Quality and Safety in Hospital Practice 2013 released earlier this month, the AMA said that although risk was inherent in hospital care, particularly in acute treatment, this could be mitigated to a large extent by effective quality and safety systems that drew upon, and were driven by, clinicians.

"The Australian health system delivers a large number of cost-effective, high quality medical and health services," the AMA said. "[But] avoidable errors still occur, and ongoing improvements can be made.

"Quality and safety systems within hospitals should harness medical practitioners' continuous motivation to improve."

The Position Statement sets out the key characteristics of an effective quality and safety system, including:

- the collection of robust and clinically relevant data;
- the deep involvement of local clinicians;
- a focus on improvement rather than blame, and giving priority to outcomes, not processes;
- acceptance that risk will never be completely eliminated;
- keeping any remedy proportionate to the risk involved; and
- assessing individual clinician performance against that of peers, not an idealised standard.

The AMA said that, to be effective, quality and safety systems needed to be supported by adequate resources, including sufficient hospital capacity (with an average bed occupancy rate of 85 per cent), good staff safety policies and procedures, and hospital IT systems easily accessible to staff and GPs to report and track adverse events and near-misses.

The AMA said another important aspect to building and maintaining public confidence in hospital care was to eschew any culture of secrecy.

"The AMA supports open communication following an adverse event, and the principle of Open Disclosure - an approach which recognises the reality of human error and respects the patient's right to know what happened."

The Position Statement can be viewed at: http://ama.com.au/position-statement/quality-and-safety-hospital-parctice-2013

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Bring study and practice together to boost health

Medical research must be "routinely performed" as part of the delivery of health services to exploit the enormous potential for alleviating sickness and improving wellbeing, according to a seminal Government report.

In a vision that has been strongly endorsed by the AMA, the Strategic Review of Health and Medical Research in Australia, chaired by former Australian of the Year Simon McKeon, has set out plans to substantially boost the nation's health and medical research effort, particularly by "embedding" scientific inquiry into the daily practice of medicine.

The McKeon Review calls for tougher scrutiny over how the existing annual allocation of $1.5 billion for research is being spent, while outlining plans for an extra injection of $2.8 billion a year by 2024.

According to the Review, such investment by the country will more than pay for itself in improved national wellbeing, a more efficient and productive health system, the generation of tens of thousands of high quality jobs and the development of a vibrant and robust export industry.

The Review estimated that for every dollar invested in health and medical research, the country would reap $2.17 in health benefits from advances in treatment and improvements in the efficiency of health services, which is vital if the country is going to be able to afford to meet swelling demand for care in the next four decades.

According to the Review, research could slash the $30 billion a year cost to the economy from lost productivity by addressing the causes and treatment of chronic disease, as well as fuelling growth in the burgeoning biotechnology sector.

There are now more than 1000 biotechnology companies operating in the country, employing around 23,000 researchers and supporting the work of a further 40,000 employed in the medicines industry.

Moreover, pharmaceutical and medicinal exports have grown at an average annual rate of 12 per cent since 1990 and collectively comprise the nation's largest manufacturing export sector.

But Mr McKeon said the key to unlocking this potential and developing Australia's health system into the best in the world in the next 10 years, was to integrate research into the delivery of health care.

He said it was clear that there was not a sufficiently strong connection between health and medical research and the delivery of health care services.

"There is no better means to do this than by fundamentally embedding research within health care delivery," Mr McKeon said. "That is to say, research must be routinely performed as part of health care delivery, and there must be greater linkage between health care providers and research organisations."

AMA Vice President Professor Geoffrey Dobb said it was a crucial recommendation.

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Professor Dobb said increased support for health and medical research was essential if the country was to gain maximum benefit from the medical expertise that exists in the nation's hospitals, universities and the broader community.

"The AMA will encourage the State and Territory governments, which have responsibility for managing the public hospital system, to take seriously the vision of embedding research into all aspects of the health system," the AMA Vice President said. "The Government must also commit to expanding health and medical research through growth in long-term and recurrent funding, especially through the National Health and Medical Research Council."

Releasing the results of the Review, Health Minister Tanya Plibersek notably avoided making explicit commitment to any of the Review's 21 recommendations.

Instead, because many of the Review's recommendations related to the operation of public hospitals, which are managed by the states and territories, Ms Plibersek said she would present them to the next intergovernmental Standing Council of Health, which brings together the nation's health ministers.

While the Federal Government is pushing some of the questions raised by the McKeon Review onto its State and Territory counterparts, it is coming under increasing pressure to deliver on promised reforms to clinical trial regulations and incentives.

Therapeutic Goods Administration figures show that the number of clinical trials being undertaken in Australia continued to slide last year, the fourth annual decline since 2007.

Just 602 clinical trials were begun last year, down 5 per cent from 2011 and 30 per cent below the 2007 high of 865 trials.

Medicines Australia Chief Executive Dr Brendan Shaw said there was fierce international competition for clinical trial investment, and the Government needed to quickly deliver on its promise to implement the recommended reforms of the Clinical Trials Action Group if the nation was to capitalise fully on its great research expertise and facilities.

Coalition health spokesman Peter Dutton reiterated the Coalition's guarantee to quarantine medical research from any funding cuts, and called on Ms Plibersek to match the commitment.

Mr Dutton's call came amid warnings from the Association of Australian Medical Research Institutes that its members faced a $70 million funding cut because of changes in the timing of NHMRC grant payments.

Under the changes, payments will be made in arrears rather than upfront, and distributed on a monthly rather than quarterly basis.

Association President Professor Brendan Crabb told *The Australian Financial Review* the changes meant the sector was facing an immediate $140 million reversal in its cash flow.

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National action needed to boost youth health

The AMA has called for the development of an over-arching youth health strategy to help stem the incidence of mental illness, corpulence and harmful behaviour among adolescents and young adults, and boost their overall wellbeing.

While progress had been made in cutting road fatality rates among young people, improving the detection of hepatitis and reducing smoking, the AMA warned that in other important respects the health of people aged between 10 and 24 years was getting worse.

In its Position Statement on the Health of Young People released earlier this month, the Association reported that in the past two decades the proportion of young people who were overweight had doubled, and the percentage of those who were considered obese had tripled.

The increasing incidence of overweight and obesity was concerning because it could lead to the development of cardiovascular disease, diabetes, asthma, osteoarthritis and some cancers, particularly as it was during adolescence that many behaviours affecting health in the long-term were established.

The Australian Research Alliance on Children and Youth reported that almost 60 per cent of young people undertook little exercise, just 5 per cent had the recommended daily intake of fruit, and almost 20 per cent of 14 to 19 year-olds took illicit drugs.

According to the Position Statement, mental health was also an important issue among young people, with mental disorders accounting for almost half of the total disease burden among those in the 10 to 24 age group, including 9 per cent who reported high or very high levels of psychological distress, while 10 in every 100,000 committed suicide.

The distinct spectrum of health concerns for young people also included the incidence of sexually transmitted diseases, injury and poisoning, the use of illicit drugs, binge drinking, poor body image and fad dieting, and excessive sun exposure.

"These behaviours and concerns could lead to serious health problems later in life if not addressed now," AMA President Dr Steve Hambleton said. "It is important to support and advise young people about staying healthy and avoiding unhealthy practices and substances."

Dr Hambleton said parents and other adults could act as a strong guide, both in word and action, about adopting and maintaining a healthy, happy lifestyle, adding that GPs also had an important role to play as a trusted source of information and advice, particularly on difficult issues such as sex, alcohol, drug use and bullying.

The AMA said that, to a large degree, the illnesses suffered by young people were preventable, but governments, doctors and health advocates had to develop more effective ways to convey information and encourage healthy behaviour.

The Position Statement said many young people hesitated to seek medical advice and treatment because of a range of concerns including cost, confidentiality and the appropriateness of the care provided, while many others were ignorant of the services on offer.

It said that not only should there be greater effort to provide information and services online, but greater attention should be paid by hospitals, clinics and individual practitioners to the way they provided care to young people.

The AMA advised practitioners that competent young patients had an ethical and legal right to confidentiality, which had to be considered in the context of other legal obligations, the demands of parents and the requirements of insurers.

The Position Statement urged hospitals to make greater effort, where possible, to place young patients in wards with others around their own age, rather than with adults or young children.

It said improvements also needed to be made in arrangements to provide ongoing care for young people with chronic conditions or disabilities during the transition from paediatric and adult care, and recommended that youth health be included in the medical training curriculum.

The AMA called for greater recognition of, and attention to, the distinct health needs of adolescents and young adults through the development of a National Health Policy for Young People, with input from young people and GPs.

It also recommended the Federal Government increase the availability of Medicare cards, and urged increased investment in youth health initiatives, particularly around prevention.

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Doctors urged to seek hospital assurances as Medicare cracks down on billing practices

Doctors have been advised to get a written guarantee from public hospitals that any billing using their provider number has not been in breach of the law amid concerns of widespread inappropriate charging.

As reported in *Australian Medicine* on 11 March (http://ausmed.ama.com.au/medicare-crackdown-public-hospital-billing), the Department of Human Services (DHS) is investigating allegations that Medicare has been effectively double-billed for pathology and diagnostic imaging services conducted in public hospital emergency departments.

In a notice to members, the AMA has advised that the Department is examining billing for diagnostic services by emergency physicians at 70 public hospitals.

"DHS is concerned that Medicare benefits may have been paid for diagnostic imaging and pathology services requested for public patients in public hospital emergency departments," the AMA said.

While hospitals and their billing practices are the focus of the investigation, the Department may also audit the claims of individual practitioners, who carry responsibility for billing claims made under their provider number.

The AMA has advised members that, where Medicare claims for services rendered in public hospitals are being billed using their name and provider number, "the practitioner must be made fully aware of, and be prepared to accept responsibility for, that billing".

The Association urged practitioners to obtain a written guarantee from hospitals that, where claims are made for services rendered in public hospitals, the arrangement is not in breach of relevant Australian Health Care Agreements, adding that public hospitals must provide doctors with full records of all medical accounts raised in their name.

Doctors who believe the use of their provider number may have contravened provisions of the Health Insurance Act have been advised to contact their State or Territory AMA office.

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More funds needed for mental health nurses

The AMA has urged the Federal Government to boost funding for a mental health program that has proven to be effective in providing ongoing care and support.

AMA President Dr Steve Hambleton has written to the Minister for Mental Health and Ageing Mark Butler calling for the injection of more money into Mental Health Nurse Incentive Program after a comprehensive evaluation found it to be beneficial and cost effective.

In last year's Budget the Government continued to support the program, but funding was capped at 2011-12 service levels.

Dr Hambleton said significant unmet demand for the service warranted its expansion, and called for the funding cap to be lifted.

"[The evaluation showed] that the program is beneficial to patients and cost effective," Dr Hambleton wrote. "The AMA believes it is appropriate for the current cap to be lifted."

The AMA President said the government's own evaluation found that there was "unmet need", and said funding should be increased to ensure reasonable access to services.

"The AMA strongly believes mental health nurses in general practice are critical to the ongoing care of those patients suffering severe and persistent mental health illness who are primarily reliant for their treatment on GPs," Dr Hambleton said.

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Respect informed choices of pregnant women, doctors told

Doctors should respect the fully informed decisions made by pregnant women, even when they go against clinical advice, such as when they reject recommendations for a caesarean section.

In a significant statement clarifying the role and responsibilities of practitioners treating pregnant women, the AMA said doctors were an important source of information and advice regarding the risks and benefits to both women and their foetuses of lifestyle and medical treatment options.

But in its *Position Statement on Maternal Decision Making 2013*, the AMA insisted that doctors were obliged to respect and abide by decisions based on full information made by their patients, even where these directly contradicted their advice.

"A doctor may not treat a competent pregnant woman who has refused consent to treatment," the Position Statement said. "Recourse to the law to impose medical advice or treatment on a competent pregnant woman is inappropriate."

The AMA said most pregnant women wanted the best for both themselves and their unborn babies, and these usually converged.

But it warned the situation became much more complex when the interests of the mother and foetus diverged, such as when the mother required life saving treatment that could seriously harm the foetus, or vice versa.

"In these circumstances, the woman is faced with making a decision that may benefit herself while seriously harming her foetus, or may benefit the foetus while seriously harming the mother," the Position Statement said. "The mother's fully informed decision should be respected."

The AMA admitted that doctors may find it distressing or challenging when a pregnant woman decided not to follow their advice, such as rejecting a recommendation for a caesarean section.

"In these situations, the doctor should explore the woman's reasons for acting against medical advice with her, [but] the doctor must respect the woman's informed decision, and continue to provide patient support," the Position Statement said.

"In the event that the doctor cannot, in good faith, continue to care for the patient, they have a duty to make timely arrangements for that patient's ongoing care."

The AMA advised that where the decision-making capacity of a pregnant woman was in doubt, the doctor should ensure she was assessed as soon as possible.

If her ability to make decisions was found to be impaired, Guardianship arrangements should be initiated.

The Position Statement can be viewed at: https://ama.com.au/position-statement/maternal-decision-making-2013

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GPs central to ageing at home

General practitioners are integral to enabling older people to live at home in comfort and with confidence for as long as possible, according to the AMA.

In an important statement on ways to improve care for the elderly as the population ages, the AMA has detailed in its *Position Statement on Community Aged Care Services 2013* the central role GPs can and should play in supporting people to age within the comfort and safety of their own home.

Demand for aged care services is expected to soar in the next 40 years, with estimates that the number of people aged between 65 and 84 years will double by 2050, and those older than 85 years expected to quadruple from 400,000 to 1.8 million.

There are mounting concerns that hospitals and the residential aged care system could be overwhelmed without effective community care, and home-based support is seen as essential to help minimise the pressure on acute and residential aged care services from the elderly.

In its Position Statement, the AMA said that older people who lived at home enjoyed a better quality of life and better health than those in institutions.

Not only were they less likely to need acute care, they also avoided some of the hazards of hospitals and aged care services, like exposure to dangerous infections.

AMA President Dr Steve Hambleton said comprehensive community aged care services "will give older Australians the confidence to remain living in their own homes for longer".

But he added that, in order to achieve this, such services needed to be tailored to meet individual need, and had to be coordinated and managed – a task he said GPs were best suited to perform.

"Most older Australians have longstanding relationships with their GP, who is best placed to determine which community services will work best for their patient," Dr Hambleton said. "The AMA believes that the ongoing need for, and provision of, community care services should be overseen by GPs."

In its Position Statement, the AMA admitted that relying on community services to stay in the home was not without risk for the elderly, with the danger that, over time, the quality of care could deteriorate and become fragmented.

But it said this could be ameliorated by making GPs the focal point for overseeing and coordinating care.

The AMA said GPs were best placed to make an early medical assessment to determine what services elderly patients needed to maintain their level of independence before their health and social circumstances deteriorated.

"Medical practitioners should undertake assessment of a patient's needs, and refer the patient to a service which would then coordinate the provision of the required service," the Position Statement said, adding that they and their patients should have easy access to information about local support services.

It added that Medicare Locals had a role in identifying local community needs and highlighting any gaps in the services on offer, and said community care services should include transport arrangements to ensure the elderly could get access to care and services not provided in the home.

Palliative Care Australia (PCA) welcomed the AMA Position Statement, which it said addressed a number of important issues such as support for carers, timely access to services, the role of GPs and the need for information for the public and medical practitioners.

"PCA supports the involvement of GPs in providing aged care services, and encourages ongoing education in best practices in palliative care to enhance delivery of care," PCA Chief Executive Officer Dr Yvonne Luxford said.

"The AMA's statement supports a community aged care system which allows older people to remain living in their own homes, for longer," Dr Luxford said. "I would add to this that a quality community aged care system should also support people to receive palliative and end of life care in their own homes, and support them to die there, if this is their wish."

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Indigenous Peoples' Medical Scholarship 2013

For the assistance and encouragement of Aboriginal and Torres Strait Islanders studying for a medical degree at an Australian University

Applications are now sought for the Australian Medical Association (AMA) Indigenous Peoples' Medical Scholarship for 2013. Applicants must be people of Aboriginal or Torres Strait Islander background.

Applicants must be currently enrolled full-time at an Australian Medical School and in at least their first year of medicine. Preference will be given to applicants who do not already hold any other substantial scholarship.

The Scholarship will be awarded on the recommendation of an advisory committee appointed by the AMA. The value of the Scholarship given in 2013 will be $9,000 per annum, paid in a lump sum each year of the course.

The Scholarship will be awarded for a full course of study, subject to review at the end of each year.

Applications close 10 May 2013

To receive further information and an application package, please contact Sandra Riley, Administration Officer, AMA on 02 6270 5452 or email sriley@ama.com.au. An application package can be downloaded from the AMA website www.ama.com.au/indigenous-peoples-medical-scholarship-2013.

The Indigenous Peoples' Medical Scholarship Trust Fund has been established with a contribution from the Australian Government. The Trust Fund is administered by the Australian Medical Association.

The Australian Medical Association would also like to acknowledge the contribution of the Reuben Pelerman Benevolent Foundation to the Indigenous Peoples' Medical Scholarship.

Scholarship to help drive increase in Indigenous medical students

The AMA is offering scholarships to Indigenous medical students amid evidence steady gains are being made in encouraging Aboriginal people and Torres Strait Islanders to become doctors.

The AMA is inviting applications from aspiring Indigenous doctors for its $9000 a year AMA Indigenous Peoples' Medical Scholarship, which has helped support many students in becoming doctors since its inception in 1995.

AMA President Dr Steve Hambleton said the Scholarship was an important initiative in helping narrow the health gap between Aboriginal people and Torres Strait Islanders and the rest of the community.

"There is evidence that there is a greater chance of improved health outcomes when Indigenous people are treated by Indigenous doctors and health professionals," Dr Hambleton said.

Figures compiled by the Medical Deans of Australia and New Zealand show that there were 70 first-year Indigenous medical students enrolled last year, with the total enrolment across all six years of study reaching 226.

The figures show the proportion of first year medical students who are Indigenous has surged from just 0.8 per cent in 2004 to 2.5 per cent last year – bringing their representation in line with their overall presence in the broader population.

But the figures also provide a sobering reminder that a high proportion of Aboriginal people and Torres Strait Islander medical students do not complete their studies.

They comprise 1.6 per cent of total domestic medical student enrolments, but just 0.5 per cent of total domestic graduations.

Dr Hambleton said "every effort" had to be made to help make it possible for Indigenous people to study medicine, and the Scholarship was helping to provide much-needed support.

"The scholarship has assisted many Indigenous men and women who may not have otherwise had the financial resources to study medicine," he said.

To be eligible for the scholarship, students must be enrolled full-time at an Australian medical school and be eligible for ABSTUDY. Applications for the scholarship close on 10 May.

Details on how to apply can be found at: http://www.ama.com.au/indigenous-peoples-medical-scholarship-2013

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Doctors, vets share superbug concerns

The rise of superbugs and action to prevent the future spread of the deadly Hendra virus to humans headed discussion held between AMA President Dr Steve Hambleton and senior Australian Veterinary Association officials earlier this month.

As international concern about the proliferation of antibiotic resistant bacteria mounts, Dr Hambelton and the AVA's President Dr Ben Gardiner, Chief Executive Officer Graham Catt and National Veterinary Director Dr Kevin Doyle met in Canberra on 16 April to discuss the scale and nature of the threat in Australia, and what the health professions can and should do to help address the problem.

The meeting followed calls from Australian infectious disease experts for re-regulation of antibiotics amid concern that "unfettered use in both humans and animals" had helped drive an alarming spike in antimicrobial resistance worldwide.

Last month, England's Chief Medical Officer Professor Dame Sally Davies warned that the rise of drug-resistant microbes posed a "catastrophic threat" to human health that could make even minor and routine medical procedures potentially deadly.

Dr Hambleton and his AVA counterparts also discussed measures to prevent the spread of the deadly Hendra virus, which has claimed the lives of four people and more than 80 horses since its first outbreak in 1994.

The drug giant Pfizer, in conjunction with CSIRO, has developed an equine Hendra vaccine that it says will help break the cycle of transmission from horses to humans.

(l to r) Graeme Catt, Dr Ben Gardiner, Dr Steve Hambleton and Dr Kevin Doyle

But there is concern that many horse owners are reluctant to have their animals immunised, leaving their horses, themselves and other horse handlers exposed to the devastating illness.

The meeting also considered the difficulty both professions experienced in attracting and retaining practitioners in rural areas.

Dr Hambleton said the discussions with the AVA were fruitful.

"There are several areas where we can swap information, learn from each other's experiences and work together to achieve mutual goals," the AMA President said.

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INFORMATION FOR MEMBERS

AMA Fee List Update – 1 April 2013

The AMA List of Medical Services and Fees (AMA List) has been updated to include new items for radiofrequency ablation for the treatment of Barrett's oesophagus, cervical artificial intervertebral disc replacement, and testing for germline mutations of the von Hippel-Lindau gene. Changes have also been made to items for the removal of rectal tumours. These items are provided in the Summary of Changes for 1 April 2013, which is available from the Members Only area of the AMA website at http://www.ama.com.au/feeslist.

The AMA Fees List Online is available from http://feeslist.ama.com.au. Members can view, print or download individual items or groups of items to suit their needs. The comma delimited (CSV) ASCII format (complete AMA List) is available for free download from the Members Only area of the AMA Website (www.ama.com.au). To access this part of the website, simply login by entering your username and password located at the top right hand side of the screen and follow these steps:

1) once you have entered your login details, from the home page hover over Resources at the top of the page;
2) a drop down box will appear. Under this, select AMA Fees List;
3) select first option, AMA List of Medical Services and Fees - 1 April 2013; and
4) download either or both the CSV (for importing into practice software) and Summary of Changes (for viewing) detailing new, amended or deleted items in the AMA List.

If you do not have Internet access, the AMA produces the AMA List on CD. If you wish to order a copy of this CD, please complete the following form and return to:

Ms Melanie Ford - AMA. PO Box 6090, KINGSTON ACT 2604

PLEASE PRINT CLEARLY

Name:_____

Address: _____

❑ I wish to order the AMA List of Medical Services and Fees on CD for $52.

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Private health insurance changes – what they mean for doctors and patients

The AMA has warned doctors that changes to Government support for private health insurance may affect the level of cover patients have for medical services.

Controversial legislation currently before Parliament would, if passed, axe the rebate paid on the component of the private health insurance premium that attracts the Lifetime Health Cover Loading from 1 July this year.

The proposed change is in addition to measures taken last year to means test private health insurance rebates and increase Medicare levy surcharges.

In a further measure aimed at reducing the Government's contribution to private health insurance, from 1 April next year the private health insurance rebate will be indexed by the lesser of either the consumer price index or the rise in commercial insurance premiums.

Last month the Government approved an average 5.6 per cent jump in health insurance premiums, though the nation's two largest insurers hit their members with above-average increases. Medibank Private raised its premiums by 6.2 per cent, and BUPA by 5.8 per cent.

> "Medical practitioners providing informed consent to their patients will need to remind patients that they should check the details of their insurance policy with their insurer"

The AMA said the effect of changes made last year to means test private insurance rebates will only begin to be felt by many higher income earners from the end of this financial year, when they file their 2012-13 tax returns.

In the lead-up to the change, tens of thousands took advantage of health fund offers to pay their premiums up to 18 months in advance, meaning that the change in policy will not be felt by many until close to the end of 2013.

The Association warned that as the cumulative effect of these changes were felt by fund members, "people might be motivated to drop their private health insurance altogether, or reduce their level of cover [in order to lower] their premiums".

It said many people who changed the level of their cover may not fully understand the consequences of their decision.

"Medical practitioners providing informed consent to their patients will need to remind patients that they should check the details of their insurance policy with their insurer," the AMA advised.

The Association said patients should be encouraged to check:

- whether there are any procedures for which they are not covered;
- the level of their excess; and
- whether they are covered for treatment in the hospital that their medical practitioner has nominated.

Means testing of the private health insurance rebate and increases to the Medicare levy surcharge apply as follows:

Singles Families	≤ $88,000 ≤ $176,000	$88,001-102,000 $176,001-204,000	$102,001-136,000 $204,001-272,000	≥ $136,001 ≥ $272,001
Rebate				
< age 65	30%	20%	10%	0%
age 65-69	35%	25%	15%	0%
age 70+	40%	30%	20%	0%
Medicare levy surcharge				
All ages	0.0%	1.0%	1.25%	1.5%

The thresholds will increase annually based on growth in average weekly earnings. Single parents and couples are subject to the family tiers.

Further information can be found at: www.privatehealth.gov.au

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Income support could boost organ donation

Organ donation rates could be pushed to a fresh record high by plans to compensate living donors up to $3600 in foregone wages.

AMA Vice President Professor Geoffrey Dobb said the Federal Government's plans for a paid-leave scheme for living donors may help encourage people considering donating an organ to go ahead.

Under the scheme, the Government plans to offer employed living donors a weekly payment equivalent to the national minimum wage – currently $606.40 – for up to six weeks, to help cover costs while recovering from the surgery.

Announcing plans for a pilot program earlier this month, Health Minister Tanya Plibersek said that living donors made an "incredibly generous gift", and deserved to be recognised and supported.

Professor Dobb said the AMA and other groups had been calling for such support for some time, and believed it would contribute to increasing rates of organ donation.

"Donating an organ is one of the bravest and most generous acts that any living donor could possibly do, and they deserve financial support as they recover from saving or enhancing another person's life," he said. "While the minimum wage sum may be modest, it will help take away some of the worry for people when they are making the courageous decision to donate an organ."

In recent years there has been steady growth in rates of organ donation, which Government data show has continued into this year.

Figures compiled by the Australia and New Zealand Organ Donation Registry show that so far this year 315 people have received an organ donation, a 28.5 per cent jump from the same period last year.

The number of donors has grown even more sharply, up by 55 per cent in the March quarter compared with the same period in 2012, to 119 people.

Parliamentary Secretary for Health and Ageing Shayne Neumann said that in March alone there had been a record 50 organ donors, "the highest monthly deceased organ donation outcome since national records began".

The results show that recent momentum in organ donation growth has been sustained.

According to the Registry, overall organ donation rates jumped by 43 per cent between 2009 and 2012, including a 22 per cent increase in heart transplants, a 30 per cent rise in lung donations and a 36 per cent leap in kidney transplants.

Transplant Society of Australia and New Zealand President Professor Peter Macdonald said transplant units across the country were experiencing the benefit of the increase in donors, with the number of transplants being performed growing sharply.

Transplant Australia Chief Executive Officer Chris Thomas said that the surge in donations since 2009 meant an extra 581 Australians had received a transplant.

Despite the improvement, Professor Dobb said the country should "be doing much better".

Demand for organs still vastly outstrips supply, with around 1600 people currently awaiting an organ transplant, and Australia has one of the lowest rates of organ donation among developed countries.

"The paid-leave scheme should provide a boost for living organ donors, but we must continue with our efforts to get more people to sign up to the Australian Organ Donation Register," he said.

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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

Penalise parents refusing jabs: AMA, *Courier Mail*, 12 April 2013

Parents who fail to ensure their children are vaccinated should face barriers to enrolling their offspring in school, AMA President Dr Steve Hambleton said, suggesting that those who chose not to immunise their children should be compelled to produce a conscientious objector firm. "We should make it difficult for parents so they do have to think twice about whether they vaccinate their children," Dr Hambleton said.

Doctors cry foul over tax claims, *Australian Financial Review*, 17 April 2013

The Australian Medical Association has warned that a proposed $2000 cap on tax deductions for self-education expenses could discourage doctors from undertaking vital training that saves lives and improves health care. AMA President Dr Steve Hambleton said most doctors spent well beyond $2000 on education and training each year.

Doctors urged to not force-feed detainees on hunger strike, *The Age*, 10 April 2013

The AMA has issued guidelines recommending that doctors respect the wishes of people who have made an informed and voluntary decision to refuse food. In its Position Statement the Association warns that "force feeding contrary to an informed and voluntary refusal [to eat food] is not justifiable". The Statement was released as 27 refugees at the Melbourne immigration detention centre took part in a hunger strike in protest at the refusal of authorities to release them into the community.

Particle health threat triggers AMA warning, *Sydney Morning Herald*, 16 April 2013

AMA President Dr Steve Hambleton told a Senate inquiry into air quality that current standards and monitoring systems do not protect people from harmful pollution. Dr Hambleton said the country urgently needed standards on ultrafine particles that can lodge deep in the lungs, and also raised concerns about exposure to carcinogenic diesel fumes.

Radio

Dr Brian Morton, 6PR Perth, 11 April 2013

Chair of the AMA Council of General Practice Dr Brian Morton backed calls by AMA President Dr Steve Hambleton for parents of children whose children have not been fully immunised to face difficulties in enrolling their offspring in school. Dr Morton said the small risk involved in vaccination was worth it to prevent the appearance and spread of deadly disease.

Dr Steve Parnis, SEN, 10 Arpil 2013

AMA Salaried Doctors Council Chair Dr Steve Parnis said children tattooing themselves and each other using basic devices and in unhygienic conditions were exposing themselves to the danger of disfigurement and hepatitis C.

Dr Hambleton, ABC Radio National, 11 April 2013

AMA President Dr Steve Hambleton commented on a study showing that just 3 per cent of doctors generated around half of all complaints made against the medical profession. Dr Hambleton said not all complaints involved clinical problems, and could include other concerns such as personality issues or long waiting times.

Dr Hambleton, ABC News Radio, 9 April 2013

AMA President Dr Steve Hambleton said closing the gap in life expectancy between Aboriginal and non-Aboriginal Australians remained one of the nation's great unresolved social and political challenges. He made the comments as the AMA reported a lift in the number of Indigenous doctors and students studying medicine, which he said was part of a bridge to improved Indigenous health.

Television

Dr Hambleton, Sky News Australia, 11 April 2013

AMA President Dr Steve Hambleton said scientific research showed that vaccination saved lives, and called for people to stop spreading misinformation and fear about the dangers of vaccination. His comments followed the release of a report showing 77,000 children nationwide were not fully immunised.

Dr Hambleton, Channel 7, 11 April 2013

The AMA has urged parents in some of Australia's wealthiest suburbs to immunise their children or risk a deadly disease outbreak, following evidence that vaccination rates in some affluent suburbs, particularly in north Sydney and in Perth, are as low as they are in disadvantaged communities.

Dr Hambleton, Today Tonight, Channel 7, 9 April 2013

AMA President Dr Steve Hambleton said there was a link between fashion models and health problems in the community, including eating disorders, over-exercise and unnecessary cosmetic surgery.

Dr Hambleton, Sky News Australia, 11 April 2013

AMA President Dr Steve Hambleton said scientific research showed that vaccination saved lives, called for people to stop spreading misinformation and fear about the dangers of vaccination. His comments followed the release of a report showing 77,000 children nationwide were not fully immunised.

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AMA in action

Dr Hambleton addresses the Senate Inquiry into Extreme Weather Events and Climate Change with AMA Senior Policy Adviser Corinne Dobson

Dr Hambleton with lifetime AMA Member Dr George Santoro

The AMA, led by its President Dr Steve Hambleton, has had a busy fortnight. Dr Hambleton attracted national attention when he voiced strong support for the benefits of vaccination. In frank comments that were reported widely by media outlets, the AMA President told a press conference at Parliament House, Canberra, that " the science is in. Vaccination saves lives. Vaccination protects our children. Anybody who spreads an anti-vaccination message is hurting our children and we've got to make sure we respond to these sorts of reports and make a difference and make sure we vaccinate our children to protect them." Dr Hambleton, who also spread his message through numerous television and radio appearances, including on ABC24, Sky News Live, and Today Tonight (where he also talked about the looming flu season), was speaking following the release of a National Health Performance Authority report showing that child immunisation rates across the nation varied significantly by postcode, with low protection against deadly diseases such as measles and whooping cough in some of the nation's wealthier areas such as Manly and Mosman, as well as the NSW north coast and south-east Queensland. Dr Hambleton also appeared on ABC's Lateline program to talk about the condition of 27 refugees on hunger strike at a Melbourne immigration detention centre. Dr Hambleton was also busy presenting the AMA's views on important health issues under consideration by Federal Parliament. He presented evidence to the Senate Inquiry into Extreme Weather Events and Climate Change, and informed a Senate Committee inquiring into air quality about the potentially harmful exposure of many Australians to airborne pollutants, particularly ultra fine particles that can lodge deep in the lungs, and carcinogenic diesel fumes. The AMA President also met with the leaders of the Australian Veterinary Association to discuss shared concerns about growing antibiotic resistance, and found time to greet lifetime AMA member Dr George Santoro, who made a surprise visit to the Federal AMA while holidaying in Canberra.

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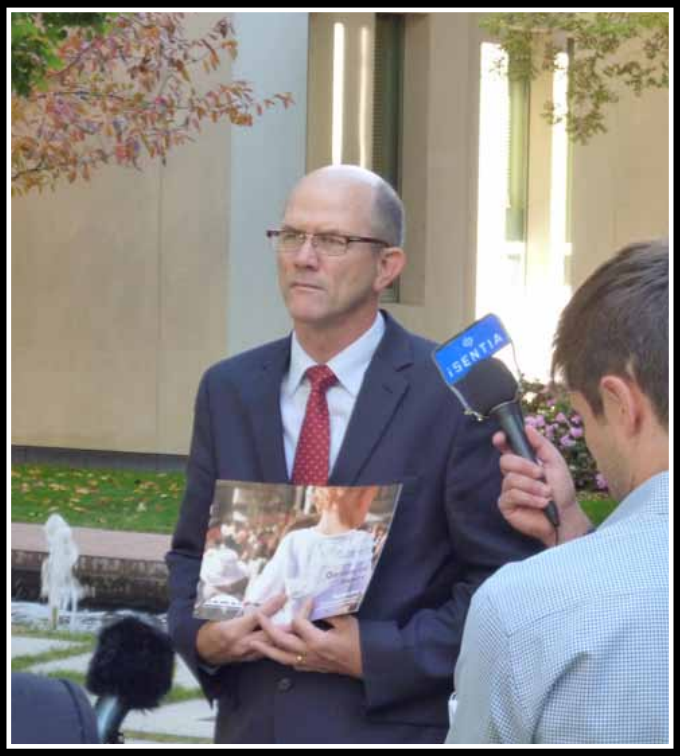
Dr Steve Hambleton talking to the media scrum about immunisation rates

AMA in action

Dr Hambleton discussing the upcoming flu season on Today Tonight



Dr Hambleton holds media conference on immunisation rates at Parliament House

Dr Hambleton on Sky News

Cash splashes don't fix waiting lists

Australian patients are languishing on some of the longest waiting lists for elective surgery in the developed world despite expensive government funding blitzes to boost treatment.

In a salutary finding for politicians looking for a quick fix to the nation's lengthy public hospital waiting lists, an international study shows that despite above average health spending and acute hospital bed provision, Australian patients on surgery waiting lists for more than four months faced the fifth longest delay among developed countries in 2010.

Those hit particularly hard were public patients awaiting knee replacements, 18 per cent of whom were forced to wait more than a year for treatment. Those in line for hip replacements also faced the possibility of lengthy delays, with 11.1 per cent waiting more than a year for their operation.

The result has come despite the Federal Government's $650 million Elective Surgery Waiting List Reduction Plan (ESWLRP), which failed to deliver a sustained drop in surgery waiting times despite funding an extra 62,000 procedures and expanding the operating capacity of more than 120 hospitals, as well as numerous initiatives by state governments.

In its study, *Waiting time policies in the health sector: What works?*, the Organisation for Economic Cooperation and Development said the result was consistent with international experience that short-term funding targeted at reducing waiting lists and times "has proved unsuccessful", either because it fails to address underlying structural problems, or because it leads to an increase in demand.

Drawing upon recent work by University of Technology, Sydney, researchers Olena Stavrunova and Oleg Yerokhin, the OECD reported that in Australia, expensive government blitzes on long surgery waiting lists have only limited success as canny patients quickly join the queue for free treatment.

Australian patients are particularly adept at swapping between the public and private health systems as the equation between cost and delay changes.

Research by Dr Stavrunova and Dr Yerokhin found that, while in the United Kingdom a 10 per cent increase in surgery waiting times cut demand by 2 per cent, in New South Wales a similar increase resulted in a much larger 17 per cent reduction in demand.

Head of Economics at the UTS Business School, Professor Elizabeth Savage, told *Australian Medicine* the results showed that Australians were particularly responsive to changes in the supply of medical services, so that if governments boosted funding to cut waiting times, more patients would join the queue for surgery.

Professor Savage, who is one of the country's leading researchers on health care funding and service use, said a key reason for this was the size of the nation's private health sector.

She said people faced a choice between free but delayed treatment in the public system, or quicker but comparatively costly care in the private sector.

"We are using waiting times to ration demand in public hospitals, because treatment is free," the UTS economist said. "You are trading off waiting times in the public system with gap payments in the private system."

Professor Savage said that when action was taken to cut elective surgery waiting times, it encouraged a proportion of patients in the private system to instead join the queue for treatment in the public system.

She said it was "exactly like" the way the volume of traffic grew to fill the space provided for it when roads were expanded or built.

Professor Savage, who co-authored a chapter in the OECD report specifically on Australia's hospital waiting lists and policies, said waiting lists in some countries, such as the United States and France, were not the significant political issue they were in Australia.

But despite the political energy and public resources devoted to cutting elective surgery waiting times, the results have been underwhelming.

Professor Savage said the evidence suggested that when governments enacted policies aimed at reducing waiting times for some patients, any improvements were usually offset by increased delays for others.

She and her co-authors found that the Commonwealth's ESWLRP saw a dramatic fall in lengthy delays for several treatments. For example, the proportion of knee replacement patients waiting more than a year for treatment plunged from 23.5 per cent to 14.9 per cent, and those awaiting cataract surgery for more than a year dropped from 12.1 per cent to 3.6 per cent.

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Cash splashes don't fix waiting lists

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But during the same period there was a general increase in median waiting times, including a blowout from 36 to 48 days for hysterectomies, and from 62 to 85 days for tonsillectomies.

"This illustrates the trade-offs that public hospitals have made to meet the targets," Professor Savage and her co-authors said, illustrating the limited effectiveness of performance targets in isolation.

"Imposing a target to reduce the percentage of patients waiting more than one year had an effect on this measure while it was in operation," they said. "The effect, however, has been to alter the distribution of waiting times: patients in the next lower urgency category (90 days) wait longer on average."

They warned that the greater responsiveness of Australian patients to changes in waiting times meant that "it is difficult to use targets or supply expansion to lower waiting times".

In its study, the OECD found that Victoria had made the greatest success of any state in Australia in achieving a sustained reduction in waiting times.

It said increasing admissions had not delivered a sustained reduction in waiting times, but measures to boost productivity by managing waiting lists for patients in specific specialties had proved effective.

In its overall conclusion, drawing on experience from across member countries, the OECD found that increasing funding to health providers as a way to cut waiting times was "almost invariably unsuccessful in brining down waiting times over the long term".

"Generally, there is a short-term burst of funding that initially reduces waiting times, but then waiting times increase…when the temporary funding runs out," the OECD said.

It found that boosting hospital productivity, such as through activity-based funding, "does not necessarily decrease waiting times".

But it said the approach being adopted in Australia and Norway to link clinical priorities to waiting time guarantees was promising, though adding that "better tools for clinical prioritisation that measure reliably clinical need and the benefit of elective procedures" were needed, as were consistent and systematic measures of waiting times.

An executive summary of the OECD report can be viewed at: http://www.oecd-ilibrary.org/social-issues-migration-health/waiting-times-for-elective-surgery-what-works_9789264179080-en

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Obese patient loses landmark legal action against GP

A morbidly obese patient has had his compensation claim against a NSW doctor thrown out by a court.

The NSW Court of Appeal has overturned a Supreme Court decision to award the man $364,000 in compensation because his GP did not refer him for bariatric surgery.

In a case that carried significant implications for how far a doctor's duty of care extended, Luis Almario sued Dr Emmanuel Varipatis, who had been his doctor between 1997 and 2011, after he developed terminal liver cancer linked to his obesity.

In a judgement that was seen to significantly extend a doctor's duty of care, the NSW Supreme Court last December accepted Mr Almario's claim that Dr Varipatis had failed in his care by not referring him for weight loss treatment and was "legally responsible" for the progression of his pre-existing liver disease to liver cancer.

But in overturning the Supreme Court's decision, the Court of Appeal found that GPs do not have any obligation "or even power" to do more than advise their patients about the need for weight loss to protect their health.

The Court said Dr Varipatis had discussed weight loss with his patient, and had given appropriate guidance, but that Mr Almario had not shown a willingness to use available services to lose weight.

But the Court of Appeal judges advised that GPs may be obliged to advise a patient that losing weight was necessary to protect their health, discuss how that might be achieved and offer referrals to appropriate specialists or clinics.

Importantly, though, the judgement suggests that if a patient refuses to take the firm advice of a GP, or specialists to whom they have been referred, there is no breach of the duty of care on the part of the GP.

Head of claims for the medical defence organisation Avant Allan Tattersall said it was an important judgement.

"[It is] a correction of the position indicated in the earlier trial which raised a doctor's duty to an unreasonable level, beyond the ability of our health care system to provide appropriate services," Mr Tattersall said. "A doctor has a duty to provide guidance; they do not, and should not, have the obligation to compel compliance with their advice."

A copy of the NSW Appeal Court judgment is available at:

http://www.caselaw.nsw.gov.au/action/PJUDG?jgmtid=164069

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Doctors wary about revalidation

Doctors are divided over proposals to introduce a revalidation system, with widespread concern it will add significantly to red tape and increase exposure to malpractice claims without doing much to boost the detection of unfit practitioners.

An online survey conducted for medical defence organisation Avant found that although many doctors were not opposed outright to revalidation, almost half were yet to be convinced existing systems were inadequate or that revalidation would make much difference.

The Medical Board of Australia (MBA) has begun examining the possibility of introducing a revalidation system, including identifying any shortcomings in current arrangements and gathering evidence about experience overseas.

MBA Chair Dr Joanna Flynn told the AMA Federal Council last month that the authority was taking an evidence-based approach to the issue, and unless there was grounds to expect a benefit to patients, the case for revalidation would be hard to make.

Chair of the AMA Council of Salaried Doctors Dr Stephen Parnis said in the last edition of *Australian Medicine* the profession should remain open to any credible evidence of a consistent failure by practitioners to meet acceptable standards.

But Dr Parnis said that before there was a rush to introduce revalidation, there should be a thorough examination of existing arrangements, and an assessment of whether adjustments could be made which would obviate the need to introduce yet another system, with all the attendant costs in time, money and resources.

More than 40 per cent of the 150 doctors surveyed by Cegedim Strategic Data Australia between 4 and 6 March said current surveillance systems were effective in ensuring doctors were fit to practice, while a further 41 per cent thought they needed refinement, and just 19 per cent believed they should be replaced.

Reflecting this, 46 per cent opposed revalidation, and the 45 per cent who agreed with its introduction expressed reservations, mostly regarding how it would be implemented and how effective it would be.

Overall, doctors were less enamoured of the potentially punitive aspects of revalidation than its potential to sustain quality of care.

Maintaining an appropriate standard of care was considered to be the most important principle on which a revalidation system should be based, followed by the detection of poorly performing doctors, with preserving public trust considered the least important rationale.

Almost half of doctors surveyed felt that revalidation would add significantly to their administrative burden, and 27 per cent thought it would expose them to more medico-legal claims.

Reflecting this, the greatest single reservation held by practitioners about such a system was the additional layer of red tape it would entail, with 43 per cent indicating this was their major concern.

The next most common issue raised was that revalidation would be ineffective in detecting doctors unfit to practice (29 per cent), while 16 per cent were worried there would not be support for doctors who failed to revalidate, and 7 per cent were concerned they may not pass a revalidation test.

Dr Parnis said the MBA should not rush into revalidation, warning that ultimately it was likely to be doctors, patients and the taxpayer who bore the cost of an extra layer of regulation.

"It would be tempting for some to assume that more is better when it comes to regulation of the medical profession, though my assessment is that the quality and rigour of existing professional regulation matters far more than adding yet another layer," he wrote.

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Govts must not shirk efforts to close health divide

Australian governments would be "irresponsible" if they did not renew their commitment to long-term funding of efforts to improve the health of Aboriginal and Torres Strait Islander people, according to the AMA.

As the nation's Federal, State and Territory leaders gathered in Canberra late last week for a Council of Australian Governments meeting, the AMA joined a range of Indigenous and health groups in calling for a renewed national commitment to closing the health gap between Indigenous Australians and the rest of the community.

Ahead of the meeting, AMA President Dr Steve Hambleton said closing the health gap must be a priority for all governments, who must not squander the progress already made in improving the health of Aboriginal and Torres Strait Islander people.

"It is a worthy goal that requires long-term funding and genuine political commitment," Dr Hambleton said.

Concern has mounted that COAG may let the issue slip when the current five-year National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes expires later this year, though the Federal Government has put a three year, $777 million offer on the table to help fund the initiative through to mid-2016.

"We are calling on COAG leaders to agree to the long-term continuation of the National Partnership Agreement, with at least the same level of funding, initially for another five years," the AMA President said. "This would send a very serious message to the community that our governments are serious about closing the gap."

There have been promising signs that progress is being made in improving the health of Aboriginal and Torres Strait Islander people.

In her annual Closing the Gap report card delivered earlier this year, Prime Minister Julia Gillard said the country was on track to halve mortality rates for Indigenous children younger than five years, there had been a significant increase in chronic health services, work was underway in partnership with Aboriginal and Torres Strait Islander people on a long-term health plan, and the target for early childhood education in remote communities was being met.

Close the Gap Campaign co-chair Mick Gooda said the policies and programs instituted in 2008 were beginning to bear fruit, but warned that there was still a long way to go to achieve health equality.

Mr Gooda said the gulf in life expectancy between Aboriginal and Torres Strait Islander people and the rest of the community was "just as unacceptable today as it was back then".

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Company beats watchdog in painkiller row

The medicines watchdog has lost out in its bid to ban the painkillers Di-Gesic and Doloxene following a long legal battle with their manufacturer.

In a dissapointing result for the regulator, the Therapeutics Goods Administration (TGA) lost its bid to pull the controversial painkillers from the market when the Administrative Appeals Tribunal ruled earlier this month that the drugs should stay on the Australian Register of Therapeutic Goods, overturning Government attempts to ban the drugs since November over concerns the key agent they contained, dextropropoxyphene, was linked to cardiac risks.

The Tribunal said it disagreed with the reasons given by the TGA for an outright ban, and suggested the government try to reach a compromise with the manufacturer Aspen to restrict access to the drugs.

Justice Duncan Kerr wrote in the Tribunal's decision that Di-Gesic and Doloxene had adequate analgesic efficacy, and he accepted that some patients did not have adequate alternatives.

"If the interests of the few can be reconciled with the interests of the many, then they should be, rather than overridden," Justice Kerr wrote.

The TGA has been granted a small window of time to negotiate with Aspen as to what restrictions, if any, should be placed on the drugs. If the two fail to agree on an arrangement, the matter will return to the tribunal for adjudication.

The Tribunal suggested that Di-Gesic and Doloxene remain available, but with highly visible warnings, and packaged in blister packs designed to minimise the risk of misuse.

The Tribunal is still waiting on further submissions from both the TGA and Aspen before it makes its formal ruling, at a date yet to be determined.

Aspen representatives told the Tribunal they would be prepared to enter into contractual arrangements with pharmacies to place additional controls on the drugs. These could involve both doctors and patients being required to affirm that that appropriate warnings about risks of using the drug had been explained to the patient.

The Chair of Consumers Health Forum Karen Carey slammed the Tribunal's decision, saying "it was alarming that a decision by the TGA that this drug is unsafe, after expert consideration of the medical evidence, can be over turned by an administrative panel".

Doctors have been advised they may continue to prescribe both products, after carefully considering the indications, warnings and contraindications in the Product Information and Consumer Medicines Information.

Di-Gesic is available at retail pharmacies, but Doloxene is currently out of stock.

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Chiropractic Board needs to back vaccination

BY **DR MICHAEL VAGG, CLINICAL SENIOR LECTURER AT DEAKIN UNIVERSITY SCHOOL OF MEDICINE & PAIN SPECIALIST AT BARWON HEALTH**

"If you get discouraged from being immunised by a chiropractor in their practice, they are breaching their professional Code of Conduct"

This article first appeared in The Conversation on 21 March 2013, and can be viewed at: http://theconversation.com/a-response-is-received-from-the-chiropractic-board-of-australia-12966

The Chiropractic Board of Australia (CBA) has responded to an article I wrote on chiropractic care of children and related concerns about chiropractors receiving continuing professional development credit for attending courses run by anti-vaccination campaigners.

First up, let me say I welcome the response from the statutory regulator to my piece. I raised what were for me some very concerning issues, and I can say that their response is reassuring in many places.

I suggested that CBA should decline to recognise CPD hours for activities found to be inappropriate and it seems that this what they are planning to do. To quote their response:

The Board is investigating the CPD assessment and approval process and will report on its findings. The Board will revoke the approval of any course not deemed to be within the area of practice for a chiropractor or any course that fails to meet its standards.

With regard to my call to emphasise the public health duty of chiropractors as an AHPRA-regulated profession, it is worth quoting again from their response:

While chiropractors may hold personal views as individuals about vaccination that do not align with the Board's position, they must not allow their personal views to interfere with the care and advice of their patients.

The Board has developed the standards that chiropractors must meet, including the Code of conduct for chiropractors, which clearly states that chiropractors have a responsibility to protect and promote the health of individuals and the community, [including] through disease prevention and control, education and, where relevant, screening. The Board investigates concerns where this is not the case. Advice about vaccinations falls outside of the expected area of practice for chiropractors. The Board expects chiropractors to refer patient questions about vaccination to other registered health practitioners who possess such training and expertise.

Half marks for that response. On the plus side, it states quite clearly that personal antivax beliefs are not to be pushed onto patients. If you get discouraged from being immunised by a chiropractor in their practice, they are breaching their professional Code of Conduct. Fair enough.

I am disappointed by their lack of outright endorsement of immunisation. Surely that's a bandwagon CBA should jump right onto! After all, it's not like it's a controversial or unconventional position. Every peak body remotely concerned with public health endorses it. It's actually bipartisan political policy, and has been for decades. No organisation apart from some of the tinfoil hat variety actually thinks that there is a problem with endorsing immunisation as a public health policy. Why do they need to be coy about their support?

With regard to chiropractic care of children, I cautiously welcome the posting of a new position statement on the CBA website. It says, in part:

Chiropractors receive extensive university training, including about caring for children. While individual chiropractors have their own beliefs and values, the Code of conduct for chiropractors makes it clear that those values must be secondary to the wellbeing of their patients and the promotion of health in

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Chiropractic Board needs to back vaccination

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their patients and the community. In maintaining good practice, practitioners should consider the balance of benefit and harm in all clinical decisions. Any care options or recommendations made to patients should be based on the best available information.

Again with the university training! I must say, as a humble doctor, our university training is not regarded as nearly good enough for unsupervised practice. The average GP these days has worked in supervised practice for at least four years before being let loose on the public, and some specialty groups take even longer than that once the 'extensive university training' is completed. In medicine, it's not unusual to spend the better part of a decade after graduation before commencing unsupervised practice. Hence the huge importance of postgraduate CPD in this debate.

It also appears the Board is happy that the university training is good enough to enable their graduates to provide 'care' for infants which has no scientific credibility, but utterly inadequate to permit them to draw the blindingly obvious conclusion that vaccines are good for kids. Puzzling.

The quoted segment refers to 'best available information', but this falls well short of my suggestion that no recommendation should be given that allows for such flimsily conceived ideas as birth subluxations, plagiocephaly treatment by chiropractic and the whole range of fanciful claims destroyed in the BCA v Singh case to prosper.

The Chiropractic and Osteopathic College of Australasia (COCA), which is the second-biggest professional organisation after the Chiropractors' Association of Australia, has made unambiguous and strong statements about these areas, which were exactly the sort of clear direction to practitioners that CBA could have chosen to give.

I can understand that CBA has no desire to get involved in the details of clinical decision-making, and is only charged with statutory regulation at a strategic level within the profession. I still find that they have left considerable room for some of their more reality-challenged practitioners to continue to get away with unscientific antics under their sleepy gaze.

So let's wait and see what the Board's CPD investigation finds out, and what their regulatory response will be. Many within and outside the chiropractic profession are hoping it will be a strong and clear message in support of the public health of Australians.

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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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Slashing red tape for chronic disease management

BY **DR BRIAN MORTON**

"The AMA will continue with its quest to see CDM items improved through the removal of unnecessary requirements"

It's been said before, and I'll say it again, the chronic disease management (CDM) items in the Medicare Benefit Schedule need to be restructured so as to eliminate red tape and to better align the items with clinically relevant practice.

As mentioned in some of my previous articles, the Government is looking to make some changes to the existing CDM items. While the AMA is cautious about the objective behind any changes, it remains optimistic that there exists an opportunity to deliver some sensible changes.

A couple of years ago, at the AMA's request, the Department of Human Services mapped the user pathways in care planning and identified which of the activities prescribed in the items have a clinical purpose, and those that have a purely administrative purpose.

In using the outcomes of this work and applying some common sense, one can identify superfluous existing administrative requirements of the CDM items that should be removed.

To begin, let's remember that a professional attendance item requires evaluating a patient's condition, formulating a treatment plan, advising the patient and others (if authorised), providing preventive health care, and recording the clinical details.

These elements are already fundamental to medical care, and do not need to be stated as requirements in the CDM items.

The requirements for CDM items should be no more complicated than the planning and management items for obstetrics (16590 or 16591). These obstetric items have none of the red tape of CDM items.

The geriatrician's comprehensive assessment and management item outlines in the descriptor that the patient's health problems and care needs are identified and prioritised; that a detailed management plan is developed and explained to the patient and/or carer; and what the management plan should include.

It does not require the patient to sign the plan or lock in a date for review. Nor does it require the geriatrician to collaborate with other health care providers; only to make recommendations about the actions and intervention strategies that would be of benefit and acceptable to the patient.

Similarly, you don't see, and nor should you, an MBS item for appendectomy or cholecystectomy that specifically details each component of the procedure to remove an appendix or gall bladder.

The detailed requirements that were included in the original enhanced primary care items in 1999 may have been appropriate then because the service was a relatively new concept. However, in 2013, management planning and team care arrangements are standard services in a GP practice.

On the subject of team care arrangements, the item is for coordinating the development of a team care arrangement, which builds on the existing management plan. It should not require a separate plan. This item should be more about the work involved in coordinating with other care providers where there is a clinical need for multidisciplinary care, and revising the management plan.

The AMA will continue with its quest to see CDM items improved through the removal of unnecessary requirements.

Whatever happens with the CDM items, it will remain one of the AMA's top priorities that they facilitate quality care and reward those who provide it.

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Universities a unique opportunity to improve mental health

BY **AMSA PRESIDENT BEN VENESS**

Six years ago, almost to the day, 33 students and staff died at Virginia Polytechnic Institute and State University ("Virginia Tech"). One of these was Seung-Hui Cho, a Korean-born student whose family immigrated to the United States during his childhood.

Mr Cho had a well-established history of mental illness, and was known to the University's multi-disciplinary "Care Team", campus police, the state Department of Mental Health, a psychiatric hospital in nearby Radford, and the university's counselling centre. For several years, his behaviour in class and residence had been observed by numerous academics and peers as markedly unusual and threatening.

On 16 April 2007, Mr Cho shot and killed 32 people, wounded 17 more, then committed suicide.

In hindsight, the shootings and suicide could be considered an expectable consequence of long-term, untreated mental illness and disaffection. That appropriate and coordinated care was never offered nor enforced upon Mr Cho represents a tragic system failure on the part of both the university and the government health service. It would seem that none of the persons who knew the most about Mr Cho's behaviour knew how to help him, and that communication between them was limited.

Such disconnection was noted broadly at Virginia Tech, and is unfortunately not uncommon at universities. One of the recommendations of the government review into the incident was that "universities should recognise their responsibility to a young, vulnerable population, and promote the sharing of information internally, and with parents, when significant circumstances pertaining to health and safety arise". Furthermore, the review called for universities to have systems that link troubled students to appropriate medical and counselling services, either on or off campus.

The events at Virgina Tech were an extreme example of the consequences of ignoring a student's mental health; students with mental health problems usually pose no threat to others. More commonly, the worst that happens is that individuals commit suicide, as happened with an international student at my university last year, and with an intern who died just a few weeks into their new job early this year.

The Australian Medical Students' Association (AMSA) spent a great deal of its first Council meeting for 2013 discussing the topic of student mental health, and passed a *Student Mental Health and Wellbeing Policy* that is available at http://www.amsa.org.au/advocacy/official-policy/.

It seeks to bring attention to this issue and forms the bedrock for AMSA's future policy initiatives in the area.

Mental health is one of Australia's nine National Health Priority Areas (predating the addition of diabetes, asthma, arthritis, obesity and dementia). Australian Institute of Health and Welfare (AIHW) data show more than one quarter (26 per cent) of the 16-24 age group experience a mental health disorder in a 12-month period – the highest incidence of any age group. Anxiety disorders are the most common, followed by substance use disorders and affective disorders. Furthermore, compared with other age groups, youth are less likely to access services for mental health problems.

There is an opportunity being missed. More than 1.2 million students are enrolled at Australia's 39 universities, and more than 60 per cent of domestic students are aged less than 25 years (by which age roughly 75 per cent of mental disorders have their onset).

Federal Government policy is to broaden access to tertiary education, with the goal that 40 per cent of 25-34 year olds hold a bachelor's degree or higher by the year 2025. This means that nearly half of all young people will soon be attending university for three, four, five, or more years – making them accessible in a way that is otherwise rare once people leave school.

AMSA would like to see universities and governments take advantage of this window of opportunity, implementing effective prevention and early intervention programmes for students' mental health.

One of the obvious starting points is regulation, so we're currently speaking to the Standards Panels that are reviewing the higher education provider standards monitored by the new industry regulator, the Tertiary Education Quality and Standards Agency.

Suggested interventions are broad, and will require collaboration between governments, universities, and students.

This is a tricky issue, but is also a battle that AMSA believes is worth the fight. The university student group includes some of the best and brightest of Australia's youth, captive in a potentially supportive environment for a small but significant number of years, and with open minds eager for opportunities for growth and personal development.

AMSA will do all it can to help them succeed.

Benjamin Veness is the President of the Australian Medical Students' Association (AMSA) and is studying medicine and a Master of Public Health at Sydney Medical School. Follow Ben on Twitter @venessb and @yourAMSA

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Clearing the dead wood

BY **DR DAVID RIVETT**

"Hard decisions must be made if we are to get the best outcomes in patient care from a cash-strapped system that cannot even afford to fairly index patient Medicare Benefits Schedule rebates annually in line with practice costs"

With the Federal Budget approaching, it is time on the farm for the annual decision to be made about which animals to keep and which to sell. Along with the steers that go to market, barren and ageing cows come top of the list to ship out.

Similarly, our national health budget needs to concentrate on retaining productive programmes and getting stuck into cutting out the deadwood.

Given that both major parties are focused on getting the budget into surplus, it is not the time to be hanging on to each and every health programme for purely sentimental reasons. 'Sacred Cows' may grace the streets of India, but they have no place in either Australian health care or on the farm.

So which holy cows are unaffordable or non-productive, and should have their funding redirected to achieve better outcomes? I would love to hear your thoughts. Just send an email to me at rivett.d@baymed.com.au

First to go on my list would be the National E-Health Transition Authority (NEHTA), which has already chewed up an obscene amount of funding with close to nil quality outcomes.

Overseas evidence of the tens of billions of dollars wasted on overarching and grandiose e-health systems, which are later discarded, must by now be ringing alarm bells amongst the mandarins in the public service. Surely, simpler, cost-effective alternatives should be considered, such as family doctors providing a simple memory stick containing core medical information to those most likely to need such. This would incur a fraction of the cost and have much sounder security.

Closely following the folly that is NEHTA, others to be culled from the Federal paddocks should be ineffective after hours help lines and Medicare Locals, while from State pastures the ever-growing raft of middle management bedevilling our hospitals needs drastic culling.

I am not suggesting that the precious and very considerable funds garnered by such pruning of these less than useful wasters of our tax dollars be folded into general revenue. Rather, I am suggesting that the dollars raised be quarantined and spent on services that actually enhance patient outcomes.

Far too often in health care we lose sight of the need to be businesslike. Hard decisions must be made if we are to get the best outcomes in patient care from a cash-strapped system that cannot even afford to fairly index patient Medicare Benefits Schedule rebates annually in line with practice costs.

Much as we may love them, and even fantasise about them doing better in the future, lame and non-productive stock have no place on a farm. Likewise in health care, grandiose and expensive programmes of no proven benefit must be shipped out, and the dollars returned to frontline service provision.

TO COMMENT CLICK HERE

Prescribing script improving, but still flawed

BY **PROFESSOR GEOFFREY DOBB**

"The AMA's position is that only medical practitioners are adequately trained to prescribe medicines autonomously"

The AMA has been lobbying for more than 12 months to influence the sensible development of a health professionals prescribing pathway by Health Workforce Australia.

Heath Workforce Australia announced the project to develop a nationally consistent approach to expanding the prescribing of medicines by registered non-medical health practitioners in January 2012.

The AMA's position is that only medical practitioners are adequately trained to prescribe medicines autonomously.

We welcome the development of a consistent platform from which registered non-medical health professionals can undertake prescribing, consistent with their scope of professional practice as determined by their education and training.

However, we argue that prescribing by non-medical health professionals should only occur within a medically delegated environment, where each member of a health professional team is collaborating with the other team members under clear and transparent arrangements.

AMA members have first hand experience of the wide range of arrangements under which non medical health practitioners prescribe medications. AMA members see the inherent risks to patient safety that arises from the inconsistency of these arrangements and, consequently, the uncertainty of who is ultimately responsible for the management and care of the patient. Without collaboration and coordination, the risks of duplication and drug interactions will increase exponentially with the number of prescribers.

This is also why the AMA has vigorously opposed the Optometry Board of Australia's guidelines for optometrists to independently manage suspected glaucoma patients without initial assessment by, and ongoing collaboration with, an ophthalmologist.

The AMA has lodged two submissions during the Health Workforce Australia's consultation process, in May 2012 [https://ama.com.au/node/7989] and March 2013 [https://ama.com.au/submission-final-hwa-prescribing-pathways-project], advocating for models of prescribing that will ensure safe and high quality prescribing.

Associate Professor John Gullotta has also worked hard to represent the AMA's views – sometimes the lone medical view – on the project advisory group.

Our lobbying has ensured that the latest version of the pathway circulated for public consultation in January this year is a significant improvement on the initial proposals. This version of the pathway recognises and emphasises the importance of:

- prescribing within scope of practice and education;
- prescribers being accountable for their actions; and
- working within a multi-disciplinary health care team.

However, the current consultation document still includes an 'autonomous' model of prescribing which we cannot support.

Health Workforce Australia is due to finalise the project and its recommendations in the next few months. It is likely a proposal will then be put to the nation's Health Ministers, as State and Territory laws ultimately regulate who can and can't prescribe.

State AMAs, with Federal AMA support, will need to lobby against any changes to regulations which allow expansion of non-medical prescribing outside of a medically led and delegated team environment.

TO COMMENT CLICK HERE

Coal Seam Gas

BY **PROFESSOR GEOFFREY DOBB**

Coal seam gas (CSG) extraction is relatively new in Australia, but has been practiced in the United States for some time.

It involves releasing gas (usually methane) from coal seams deep underground, often by injecting highly pressurised water and other chemicals into the coal seams to break them up.

CSG mining is sometimes seen as a relatively 'clean' form of mining, in terms of greenhouse emissions. However, the CSG mining extracts very large volumes of water and produces large amounts of waste salt.

CSG is just one form of unconventional gas extraction, with shale deposits offering another potential source of supply.

Australia has experienced rapid growth in CSG mining, with exploration and production licences covering much of the land mass. In the five years leading up to 2008, CSG production in Australia increased by 32 per cent a year (references available on request).

It has been suggested that one of the major risks of CSG mining is contamination of surface and groundwater supplies.

This is of particular concern because much of the CSG development has been associated with the Great Artesian Basin, one of the largest underground water reservoirs in the world, covering about 22 per cent of Australia's land mass.

Little is known about the nature and doses of the chemical mixtures that are used during the mining process. This makes it difficult to accurately predict and measure the associated impacts on human health and the environment.

> "The statement called for a precautionary approach to policy, and for potential intergenerational consequences to be considered"

However, a number of the chemicals typically used in CSG extraction have been associated with hormonal disruption, fertility and reproductive effects, and the development of some cancers.

While some evidence exists from US operations of environmental contamination, there is relatively limited evidence so far regarding the actual health effects of CSG in Australian.

In 2012, a NSW parliamentary committee completed an inquiry into the environmental, economic and social impacts of CSG activities. In relation to health issues, the inquiry concluded:

- more data is needed on the impact of CSG on contamination or depletion of water resources;
- the chemicals used in CSG need to be tested more comprehensively; and
- CSG companies may not all be meeting their obligations.

A risk assessment of CSG operations in the Tara region in Queensland, published in 2013, failed to find a clear link between health complaints by some residents in the area and the impact of CSG activity on air, water or soil quality within the community.

Despite this, concerns are growing among many health groups.

A coalition of organisations including the Public Health Association of Australia, the Climate and Health Alliance, the National Rural Health Alliance, the Climate Change Health Research Network and the Australian Healthcare and Hospitals Association, recently hosted the Health and Energy Roundtable.

In a joint statement, the coalition noted that the risks to human health from energy and resources policy were not being well accounted for in current policy decisions. The statement called for a precautionary approach to policy, and for potential intergenerational consequences to be considered.

Members of the Public Health and Child & Youth Health Committee recently discussed CSG and its potential impacts on human health and the environment. Accepting that CSG extraction is likely to continue in Australia, Committee members voiced strong support for the establishment of an appropriate monitoring system for all CSG developments. Committee members also agreed that there was a critical need for health implications to be a key part of the CSG approval processes.

This is an issue the Committee will continue to monitor, and AMA members with additional information are invited to forward it to the Committee.

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Health on the hill

Political news from the nation's capital

A few doctors incur wrath of the many

Medical regulators have been urged to intervene more quickly in the care provided by doctors who are the subject of multiple patient complaints following revelations that a tiny fraction of practitioners are the source of almost half of all accusations made against the medical workforce.

A study of 18,907 formal complaints against doctors lodged with authorities between 2000 and 2011 found that 49 per cent involved just 3 per cent of the nation's medical workforce, and a mere 1 per cent – less than 500 doctors – were the source of 25 per cent of all complaints.

The authors of the study, published in *BMJ Quality & Safety Online First*, said the extent to which complaints were concentrated in a small group of doctors was "striking", and pointed the way to much more targeted and effective action to head off problems early.

They said the study provided a way to predict which practitioners were at heightened risk of being the subject of patient complaints.

They found that the risk of recurrent problems virtually doubled for doctors who were the subject of two prior complaints, and increased 30-fold for those with 10 or more complaints against them.

"For some predictors, particularly the number of previous complaints, doctors' risks of additional complaints were non-linear: the risk tends to rise quickly over the several months after a complaint and then level off by the time the doctor reaches a year without further incidents," the study said.

"There is a pressing need for interventions that address the behaviour of doctors who are chronically complained or claimed against," the authors, led by Dr Marie Bismark of the University of Melbourne said. "Our study identifies a target population within which systematic deployment of interventions to improve performance might be manageable: less than 500 doctors."

The authors said the study showed the importance of prompt intervention by regulators to act on early warning signs of problematic behaviour.

"Remediation activities targeted at doctors who have attracted many complaints, while critical, come too late," they said. "By the time multiple complaints have accrued, substantial damage to quality of care is likely to have occurred already."

They recommended that "immediate steps to improve, guide or constrain the care being provided by these high-risk practitioners could be a very cost-effective way to advance quality and safety, and produce measurable benefits at the system level".

A former New Zealand Health and Disability Commissioner Professor Ron Paterson suggested that once a certain threshold of complaints against a doctor had been reached, they should be publicly divulged.

AMA President Dr Steve Hambleton said there was obviously scope for regulators to act more quickly when practitioners were the subject of multiple complaints.

"Clearly there is an issue if some doctors are subject to five [separate complaints]," Dr Hambleton told *Six Minutes*. "It is a signal that there is a need to act. There is work to be done."

But he warned Professor Paterson's proposal would leave practitioners open to unscrupulous and unjustified attack.

Dr Hambleton told *Medical Observer* it would be "far too easy for vindictive individuals to name and shame someone if that was the case, so that's not what we are after".

He said the study's findings provided a compelling argument against calls for the introduction of a revalidation regime, because "here we have a group of individuals who we could focus efforts on and achieve the goal, rather than having 97 per cent of people doing something that's wasting their time".

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High bar set to dob in a doctor

Doctors have been warned that they need more evidence than just rumours or suspicions when deciding whether or not the conduct of colleague warrants official notification.

In draft guidelines on the conduct of health practitioners and the system of mandatory notifications, the Australian Health Practitioner Regulation Agency (AHPRA) has warned that the criteria for determining whether or not conduct may be notifiable were stringent.

"The threshold to be met to trigger a mandatory notification in relation to a practitioner is high," AHPRA said. "Making a mandatory notification is a serious step to prevent the public from being placed at risk of harm, and should only be taken on sufficient grounds."

The regulator warned that before making a notification about a colleague or employee, practitioners or employers must have formed a "reasonable belief" that their behaviour puts the public at risk.

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Health on the hill

Political news from the nation's capital

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"A reasonable belief requires a stronger level of knowledge than a mere suspicion," the draft AHPRA guidelines said. "Generally it would involve direct knowledge or observation of the behaviour. Mere speculation, rumours, gossip or innuendo are not enough."

But not only must knowledge of the behaviour in question be well grounded, it must present a serious risk to the public.

"The focus [is] on behaviour that puts the public at risk of harm, rather than not liking the way someone else does something, or feeling that they could do their job better," the guidelines said. "Similarly, of the only risk is to the practitioner him or herself, the threshold for making a mandatory notification would not be reached."

The AHPRA has attempted to clarify what conduct would be notifiable as part of an overall audit of professional conduct guidelines for health practitioners.

The Agency has opened guidelines and codes of conduct for 14 professions and 530,000 registered practitioners - covering everything from whether it is okay to have sex with a patient or have a drink, to improper use of social media and how a practice can advertise - up for comment.

Though the draft guidelines and codes do not include any proposed changes, AHPRA has invited the public to make submissions by 30 May regarding any modification they would like to see made to existing rules.

Under the draft code, it would be mandatory to report a doctor who treated a patient while "under the influence" of drugs or alcohol, though not if they are intoxicated in their private life.

The situation was considered to be a little murkier when it came to sex with current and former patients.

The guidelines make it clear that "sexual activity with a current patient will constitute sexual misconduct…regardless if whether the patient consented or not. This is because of the power imbalance between practitioners and their patients".

But they are less clear-cut when it comes to sex with a former patient, which may or may not amount to misconduct depending on a range of factors including the age, capacity and health of the former patients, and the length of time between the end of the doctor-patient relationship and the beginning of sexual relations.

To view the draft guidelines and advice advice about making a submission, visit:

www.ahpra.gov.au/News/Current-Consultations.aspx

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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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Research

Male baldness linked to heart disease

Males now have another reason to worry about going bald.

A study has found that balding men are around 30 per cent more likely to develop coronary artery disease than those who retain a full head of hair.

The study, undertaken by researchers at the University of Tokyo, found that male pattern baldness is linked to an increased risk of coronary heart disease, but only if hair loss is from the top of the head. The risk is also greater the younger a male loses his hair.

The study reviewed six research papers that involved almost 40,000 men who were tracked over a period of at least 11 years.

The research found that, on average, men who had lost most of their hair by the time they were 55 years of age were were 32 per cent more likely to develop coronary artery disease than those who kept their hair.

Lead researcher Dr Tomohide Yamada from the University of Tokyo said "cardiovascular risk factors should be assessed carefully in men with vertex baldness and they should be encouraged to improve their cardiovascular risk profile".

"We recommend a heart-healthy lifestyle that includes a low-fat diet, exercise and less stress," Dr Yamada said.

Heart Foundation cardiovascular director Dr Robert Grenfell told the *Courier Mail* that, although the findings were interesting, more research was needed to confirm any link between hair loss and heart disease.

"The best judge of your heart disease risk is not the mirror or your hairdresser, it's your GP," Dr Grenfell said.

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Solomon Islands struggling to contain dengue fever outbreak

Australia has sent a team of doctors, nurses and public health experts to the Solomon Islands to assist efforts to contain an outbreak of dengue fever that is sweeping the country and has so far killed three people and left thousands more ill.

Dengue fever first appeared in the Solomon Islands in January after the country was hit by an earthquake and tsunami.

Since then, the Solomon Island Ministry of Health and Medical Services has recorded more than 2000 cases of the infection, with Senator Bob Carr saying 276 cases were reported over a five day period earlier in this month.

Senator Carr said an initial assessment team was deployed to the Solomon Islands at the beginning of April, but an additional nine-member taskforce was sent to assist local medical authorities help control the outbreak, and a 10-person medical taskforce will be held on standby to deploy at short notice if needed.

The Permanent Secretary of the Solomon Islands Ministry of Health Dr Lester Ross said the assistance would be very useful in the battle against the disease.

"The deployment will help solve the problems of human resource shortage and technical people we are lacking, and also will help strengthen the Ministry's response and ability to manage the dengue outbreak," Dr Ross said.

Dr Ross confirmed that, as at 12 April, three people had died from the fever, and said the outbreak seemed to still be building.

New Zealand has also sent a team to assist with efforts to bring the infection under control.

It is expected that the teams will spend a month in the country, and will travel to outlying provinces if needed.

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Red meat nutrient bad for heart health: study

A nutrient found in red meat and some weight loss supplements could increase the risk of developing heart disease.

Researchers have found a link between the compound L-carnitine, commonly found in red meat, and heart disease.

In addition to its appearance in red meat, the compound is promoted as a agent to help burn fat, build muscle and, ironically, protect the heart, and capsules of L-carnitine are widely available in health food stores and online.

Researchers found that the nutrient causes damage when it is broken down in the gut to produce the potentially dangerous compound, trimethylamine N-oxide (TMAO). TMAO has previously been linked to heart and artery damage.

The researchers examined more than 2500 patients undergoing heart check ups, and discovered significant dose-dependant associations between levels of the nutrient and the risk of heart disease.

Meat-eaters were found to produce significantly higher levels of TMAO than vegetarians after consuming L-carnitine. The researchers said this suggested that, as well as containing L-carnitine, red meat

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Research

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favoured the growth of gut bacteria that use the nutrient as an energy source.

When tested on mice, L-carnitine supplements significantly increased TMAO levels and artery damage, but not if their gut bacteria was suppressed.

Lead researcher Dr Stanley Hazen from the Cleveland Clinic in Ohio said, "discovery of a link between L-carnitine ingestion, gut microbiota metabolism and cardiovascular disease risk has broad health-related implications".

"The bacteria living in our digestive tracts are dictated by our long-term dietary patterns. A diet high in carnitine actually shifts our gut microbe composition to those that like carnitine, making meat eaters even more susceptible to forming TMAO and its artery-clogging effects," Dr Hanzen said.

But Australian experts say more work needs to be done to confirm a causative link between L-carnitine and heart disease.

Director of the Baker IDI Heart and Diabetes Institute Professor Garry Jennings told 6 minutes that the findings were unconvincing. "While this paper makes some clever observations, the overall evidence that red meat is harmful is not consistent with a broader body of evidence. Some studies have shown a moderate adverse effect, others only with processed meats and others have shown no risk associated with red meat," Professor Jennings said.

The study was published in *Nature Medicine*.

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Doctors give poor prognosis for medical profession

Doctors in the United States are pessimistic about the future of the medical profession amid concerns about the erosion of clinical autonomy and income.

A survey by the Deloitte Center for Health Solutions found that although almost 70 per cent of physicians were satisfied with their jobs, a majority believed the practice of medicine was being jeopardised by changes taking place that they thought would undercut earnings and compromise independence.

The online survey of 613 doctors, which had a 3.89 margin of error at the 95 per cent confidence level, found that half believe incomes will fall dramatically within the next three years, reflecting ongoing uncertainty about the effect of the Obama administration's Affordable Care Act (ACA), concerns regarding the adequacy of Medicare and Medicaid reimbursements and the ongoing failure to achieve medical liability reform.

Around 40 per cent reported that their take-home pay shrank last year, with almost half experiencing a drop of more than 10 per cent – a decline many blamed on the ACA.

Coupled with this has been a shift away from solo work toward group practices.

Almost a third of those surveyed said they had consolidated their practice into a larger organisation in the previous two years, most commonly to gain or retain income security (29 per cent) or to improve their bargaining power with those paying for services (21 per cent).

This trend is expected to continue, with 70 per cent believing that larger practices and multi-disciplinary groups offer the greatest potential for financial success, albeit at the cost of a significant degree of clinical autonomy.

Of those physicians happy in their work, the greatest source of satisfaction came from relationships with patients (37 per cent), protecting or promoting the health of individuals (32 per cent) and intellectual stimulation (19 per cent).

Belying the idea that doctors are mostly in it for status and money, just 5 per cent of those who found fulfilment in practising medicine relished the financial rewards and only 2 per cent derived satisfaction from a sense of prestige.

But just as revealing were the responses of those disaffected with medicine, the majority of whom were primary care providers.

The main sources of dissatisfaction were insufficient time with each patient, long hours and dealing with the burden of Government regulation.

Reflecting pessimism about the future of the profession, 60 per cent of those surveyed thought it likely that many would retire earlier than planned in the next three years, and around 75 per cent thought a medical career would no longer appeal to the "best and brightest".

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Measles outbreak linked to discredited anti-vax study

A discredited study linking vaccination with autism has been blamed for contributing to a measles outbreak in Wales affecting more than 600 young people.

Hundreds of anxious parents and their children queued up at hospitals and clinics in South Wales for the measles, mumps, rubella (MMR) vaccine after health authorities urged all those younger than 43 years who had not had measles, or been vaccinated against it, to be immunised.

The epicentre of the outbreak is Swansea, where a local newspaper campaigned against the MMR vaccine during the late 1990s and early last decade based on the findings of a study – since discredited – that claimed to have found a link between the vaccine and bowel disease and autism.

Other researchers were unable to replicate the findings and the principal author of the study, Andrew Wakefield, was found by the British General Medical Council in 2010 to have acted dishonestly and irresponsibly in his research and was struck off the Medical Register. *The Lancet*, which had published the paper in 1998, fully retracted it.

But health experts said the research, by triggering international concern about the safety of the MMR vaccine, had probably contributed to the current outbreak of measles, which is a potentially deadly disease for which there is no treatment.

Before the Wakefield paper was published, around 92 per cent of children in the United Kingdom received the MMR vaccination, but the rate fell sharply to 80 per cent in 2003-04, before recovering to reach above 91 per cent in 2011-12.

Figures compiled by the Wales Health Protection Agency show that there were just two confirmed cases of measles between 1996 and 2000, but by the disease became increasingly prevalent from 2003 onwards, with almost 160 confirmed infections in 2009 and 116 last year.

Following the introduction of MMR vaccine in October 1988 and the achievement of coverage levels in excess of 90 per cent, notifications of measles fell progressively to the lowest levels since records began and the spread of measles was effectively halted by the mid 1990s," Public Health Wales said. "However, 2006 saw an increase in the number of confirmed cases and the first reported death from measles in the UK for 14 years. The rise in the cases of measles may be attributable to the lower uptake of the MMR vaccine in recent years in the wake of negative publicity surrounding unfounded claims of a link between MMR and autism.

Dr Roland Salmon, consultant epidemiologist for Public Health Wales, told *The Telegraph* that drop in vaccination rates associated with the MMR furore had left many young people vulnerable to the disease.

"Unfortunately, there is a cohort of young people who weren't vaccinated and have now reached secondary school," Dr Salmon said. "As their social contacts are increasing, so are their chances of catching and developing the disease."

Dr Salmon attributed the outbreak, at least in part, to anti-vaccination campaigns that had left many exposed to infection.

"There was a sustained campaign against MMR by the local evening paper [the *South Wales Evening Post* in the late 1990s], and my colleagues noted at the time that its circulation area had a proportionate fall in vaccinations compared to other regions in Wales. So there is a connection," says Dr Salmon.

There are signs the outbreak is coming under control, with less than 50 cases confirmed cases in the week after Easter, about half the rate registered the previous week, leading health authorities to be optimistic the spread of the disease had been stemmed.

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New front opens in US abortion battle

An American state has introduced laws that ban abortions as early as six weeks into pregnancy, in the boldest government action yet to curb pregnancy terminations.

North Dakota has passed three laws that ban an abortion when a foetal heartbeat can be detected, or when it is being performed due to foetal genetic abnormalities or for gender selection.

The legislation also requires that doctors who perform abortions must have admitting privileges at a local hospital.

The new laws do not specify what techniques could be used to discern a foetal heartbeat, and medical experts warned that vaginal ultrasounds can detect them extremely early in pregnancy, a soon as six weeks form conception.

The action is the latest salvo in the long-running battle in the United States over the right of women to have access to abortion, particularly as established by the US Supreme Court in the landmark 1973 Roe versus Wade case.

North Dakota Governor Jack Dalrymple told *amednews.com* the laws were a legitimate attempt to "discover the boundaries of Roe versus Wade", and his government was preparing a litigation fund in anticipation they would be challenged in the courts.

"Because the US Supreme Court has allowed state restrictions on the performing of abortions, and because the Supreme Court has never considered this precise restriction in [North Dakota's foetal heartbeat law], the constitutionality of this measure is an open question," Mr Dalrymple said.

A family planning group, Planned Parenthood Minnesota, North Dakota, South Dakota, warned the laws would affect the ability of doctors to treat serious conditions such as ectopic pregnancies, as well as undermining in vitro fertilisation practises.

Doctors have also public voiced their opposition to the new laws.

North Dakota Medical Association Executive Director Courtney Koebele told *amednews.com* that although her organisation did not have a pro or anti-abortion policy, the dangers to patient health and restrictions on medical practice posed by the laws meant it could not remain silent.

"As a member organisation, we try not to take a stand one way or the other on abortion," Ms Koebele said. "However, upon examination of these bills, it was determined that they just interfered too much with the patient-physician relationship."

She said the Association also objected to the requirement that doctors who perform abortions have privileges at local hospitals, particularly because many of the doctors who carry out the procedure in North Dakota come from Minnesota, do not have admitting privileges at the two major hospitals near the abortion clinic, and were unlikely to be granted them.

"It's treating this type of procedure different than other types of procedures. There are plenty of procedures that are done outside the hospital that could be considered surgery," Ms Koebele said.

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The grape doesn't fall far from the vine

BY **DR MICHAEL RYAN**

Who is David Franz? A designer, raconteur, wordsmith, artist, prestidigitator? Yes to all of these. Perhaps he is the alter ego of David Franz Lehman. Maybe it's akin to a Jekyll and Hyde scenario.

No, he is just one crazy, energetic artisan that has a blue blood pedigree, being the son of the masterful Peter Lehman from the Barossa. He chooses to fly under his own banner as David Franz.

There is a fire in the eyes of this larrikin that streams from a heart that is generous and true to his cause.

The production of handcrafted wines, handled with kid gloves, which express a vineyard's gifts, has always been David Franz's aim.

He handles every process, from grape growing to the production of artful screen-printed labels that adorn each of his babies. Getting there has been a long journey that has seen him work as a farm hand, a hotel cleaner and even a roustabout. He has worked vintages in South Africa, and as a wine hand with Oddbins in England. He really wanted to be a cartoonist and university was never his bag.

His first vintage was in 1998, when he was still working for Lehman's, and was a Shiraz and Cabernet blend. Through subsequent vintages he has gleaned knowledge from the experienced heads around him, which he has combined with an instinctual belief in what he does.

Convention doesn't sail on the ship of David Franz. Just have a look at the labels of his "POP" series, which includes a great Barossa Cabernet-Shiraz-Grenache blend, as well as a straight Grenache, while the most recent release is a straight Cabernet Sauvignon.

His drive to create and explore new territory is evident in the production of Petit Verdot and Pinot Noir.

I asked him where he sees himself in the next 10 to 20 years, to which he responded: "Doing this, only better. The time you don't want to be better at something is the time to give it away."

Wise words from a vinous troubadour whose wine notes will dance on and delight the palates of generations to come. .

Wines Tasted

2011 Long Gully Barossa Semillon

I think this tops most Hunter Valley Semillons, with a delightful yellow hue and a lemon zest and grassy nose that has hints of yeasty notes. The palate is balanced fruit and acidity, but certainly leaves crispness in the mouth. This will age beautifully over a decade, and would go well with an elegant Thai chicken salad.

2010 Brother's Ilk Adelaide Hills Chardonnay

Attention to detail is typified by this wine, with meticulous fruit selection from Birdswood. It involves 100 per cent barrel fermentation, and good yeast contact adds to its complexity. Green and yellow hues are noted in the colour. The nose races with initial white peach and citrus notes, with complex meaty overtones and the odd spice aroma. The palate is full, generous but balanced. This is a lip smacking good Chardonnay that will age for five to seven years, and would suit oven baked snapper and tarragon-infused Hollandaise.

2007 Georgie's Walk Barossa Cabernet Sauvignon

The man is a genius with respect to Barossa Cabernet. Never my favourite grape variety out of Barossa, as it can be over-ripe, but Dave Lehman has created a rich, dark brew, with a cornucopia of aromas ranging from red fruits and plums to dates, with hints of oak and spice. As it evolves in the glass, it liberates liquorice and star anise notes as they ride the chocolate wave. Cellar for 20 years, as I have some 12-year-old David Franz Cabernet, and it is still lively.

2007 Benjamin's Promise Barossa Shiraz

Sensual dark purple and garnet rim colours are noted. The nose erupts with classic plums and dates, with spicy, earthy notes. Hints of chocolate and tobacco emerge. The generous palate surfs on and delights the senses. Another 20 year long liver. Have with gourmet wagyu pie.

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