AUSTRALIAN
Medicine
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New Government, New Direction

Will the Coalition 'under-promise and over-deliver' on health?, p3

Inside

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New Government – will it 'under-promise and over-deliver' on health?

BY AMA PRESIDENT DR STEVE HAMBLETON

"Tough economic conditions still prevail nationally and internationally, so health investment must be clever and targeted to maximise the impact of every health dollar"

We have a new Coalition Government after a convincing election win on Saturday, but what will this mean for health?

There were a number of consistent themes from various Coalition spokespeople throughout the campaign that may give us a clue – '*no cuts to health', 'less bureaucracy',* and *'focus on frontline services*'.

These themes are borne out in the health policies that the Coalition took to the election.

There will be a review of Medicare Locals, and the AMA will seek to be actively involved in that review to ensure that GPs have a leadership role in these organisations.

A number of the many new agencies in the health portfolio will be scrapped or merged.

There will be more GP infrastructure grants to help expand existing general practices.

We anticipate an end to – or at least a rationalisation of – the expensive and inefficient GP Super Clinics program.

And there are strong signs that the Coalition will adopt a more practical approach to the introduction of the electronic health record.

We were engaged with the Coalition in Opposition. There was close and regular consultation and our ideas and views were taken on board, as evidenced by the election health policies. We expect this close relationship to continue in Government.

Both incoming Prime Minister Tony Abbott and probable Health Minister Peter Dutton have long expressed strong support for general practice as the cornerstone of primary health care, and we can expect this support to transform into long-term policy over time.

They are also both committed to medical training and medical research. We anticipate leadership at COAG to solve the medical training pipeline problems.

The AMA backs the Coalition's less bureaucracy, more frontline services approach. And that is what patients want, too.

While the Coalition's health policies are, by their own admission, modest as far as new funding goes, they are practical and affordable, consistent with the AMA's policy prescription in our *Key Health Issues* election document.

Tough economic conditions still prevail nationally and internationally, so health investment must be clever and targeted to maximise the impact of every health dollar.

The priority is to protect and support the fundamentals of the health system – the things that work – and ensure that every program and service has a direct patient benefit.

We are fortunate that the new Prime Minister has a strong health pedigree.

Tony Abbott was Health Minister in the Howard Government and has an impressive track record.

He personally oversaw the implementation of measures that fixed the medical indemnity crisis.

He increased the general practice Medicare rebates to 100 per cent of the scheduled fee in response to declining bulk-billing rates, and he routinely called the Howard Government '*the best friend that Medicare ever had*'.

He presided over the introduction of graphic health warnings on cigarette packets, against the wishes of Big Tobacco.

And he also put in place measures to dramatically increase medical student numbers.

He listened to the AMA and the medical profession then, and we are confident he will do the same now and in the future.

Throughout the election campaign, Tony Abbott said that he would "*under-promise and over-deliver*".

If that becomes the Coalition slogan for health reform, we will have an exciting few years ahead.

TO COMMENT CLICK HERE

Federal Election 2013 – The Verdict

"We wish Julia Gillard and Nicola Roxon every success in their post-politics careers and look forward to working with Tanya Plibersek and Kevin Rudd in their new roles in Opposition"

As *Australian Medicine* neared deadline, the Australian Electoral Commission (AEC) website had the Coalition on 86 seats, Labor with 57, the Greens with one (Adam Bandt), Andrew Wilkie retaining his seat in Tasmania, Bob Katter winning his Party's only seat, and four undecided.

With six seats – Barton, Eden-Monaro, Reid, McEwen, Capricornia, and Petrie – all in the 'close' category with votes still being counted, the total tally for each of the major Parties could still change slightly

Clive Palmer is still a chance of winning Fairfax. It looks like Sophie Mirabella has a fight on her hands in Indi.

Former AMA President Dr Bill Glasson gave Kevin Rudd a big scare in Griffith (Qld), but it may not be all over for 'Wild Bill'. Former PM Rudd has stood down as Labor leader, but there is speculation he might leave Parliament altogether, which would give Dr Glasson another shot in a by-election should he choose to run.

The ABC's Antony Green, meanwhile, is predicting 89-57 to the Coalition, with Bandt, Wilkie, Katter and Palmer making up the numbers.

The ABC has the new Senate – to be installed from 1 July 2014 – as Coalition 33, Labor 25, Greens 10, DLP 1, and Others 7. As counting continues, a lot of people will be focused on the Others, as they will have a strong bearing on how much work Tony Abbott will have to do to get his legislation through both Houses.

AMA President Dr Steve Hambleton congratulated Tony Abbott and the Coalition on winning Government.

"We have a strong foundation with the new Coalition Government and look forward to a cooperative and constructive working relationship," he said.

Dr Hambleton also paid tribute to the outgoing administration.

"The AMA at all times had access to Prime Ministers Kevin Rudd and Julia Gillard, both of whom took the advice and views of the AMA seriously," he said.

"Tanya Plibersek and Nicola Roxon were both quality Health Ministers who will leave a strong legacy in the health sector, especially in public health.

"The tobacco plain packaging legislation is a landmark achievement by Labor in Government.

"We wish Julia Gillard and Nicola Roxon every success in their post-politics careers and look forward to working with Tanya Plibersek and Kevin Rudd in their new roles in Opposition."

John Flannery

TO COMMENT CLICK HERE

Australian **Federal Election** 2013

Promises, Promises – Health in 2013 Election

What did the Coalition promised on health policy…?

Announcement	Date	Cost	Comment/reaction
COALITION			
Medicare Locals to be reviewed	24 May	n.a.	
Medibank Private to be sold off	Could be delayed	tbc	Greens don't rule out supporting sell off
Private health insurance means test to be scrapped	24 May	tbc	
Government policy to cap indexation of private health insurance rebate backed	27 May	$700 million saving	
National Health and Medical Research Council funding guaranteed	24 June	$3.7 billion	
Indigenous Advisory Council	11 August	n.a.	
Disability and Carers policy	20 August	tbc	Coalition will implement the National Disability Insurance Scheme
National Diabetes Strategy and research into Type One Diabetes	22 August	$35 million	
GP teaching and supervision	22 August	$52.5 million	Used to expand GP practices
PIP payments for teaching	22 August	$119 million	PIP payments will double from $100 to $200 for teaching in general practice
Medical internships	22 August	$40 million	Commit to 100 medical internships, each year for 4 years
Nursing and Allied health	22 August		500 extra scholarships for nursing and allied health
Bowel Cancer screening	22 August	tbc	Bring forward the roll out of the Bowel Cancer Screening program
Australian Institute of Tropical Health and Medicine	22 August	$42 million	
Restore independence of the Pharmaceutical Benefits Advisory Committee	22 August	n.a.	
Grafton Hospital ambulatory care	27 August	$10 million	
Mental Health Policy	30 August	$18 million	National Centre for Excellence in Youth Mental Health

n.a. – not applicable, tbc – to be confirmed. This is a guide only. May not be conclusive. Some policies may be re-announcements.

TO COMMENT CLICK HERE

Federal election campaign – ennui at the end

For people desperately waiting for a health policy of substance to suddenly emerge, the final week of the election campaign was a bit like Beckett's *Waiting for Godot* – "*Nothing happens, nobody comes, nobody goes, it's awful.*"

It was awful indeed, and not just on health. There was a total lack of colour and movement or drama or surprise – and not even a significant gaffe – to keep the public, the media, or lobby groups interested or excited in week five of the campaign.

Everybody stuck to their scripts pretty much, and they were not very good scripts. As a result, there was not much evidence of votes shifting – the trusted polls were showing numbers like 54-46, 53-47, 52-48 two party preferred, which indicated a comfortable victory for the Coalition.

On the day before the election, everybody had a view, an opinion, a prediction.

Some were saying there could be a minor swing back to the Government on polling day, but not enough to win – just enough to save some seats. Others said if a swing was on, it could be a wipeout for Labor.

The noted psephologist, Malcolm Mackerass, told fellow diners at Kevin Rudd's National Press Club address last Thursday that he predicted 94 seats for the Coalition, 54 to Labor, and two Independents.

Dennis Atkins from the Courier Mail went further, predicting more than 100 seats to the Coalition and fewer than 50 to Labor, with Queensland and western Sydney to rain destruction on Kevin Rudd and his team.

The campaign end was full of ennui. It was hard to stay focused. Reality TV was looking good.

The week began with the Labor campaign launch in Brisbane. There was lots of fanfare and confidence and 'Labor legends' in the room, but the mood soon changed by Monday with polls showing Labor hopelessly lagging, treading water in Queensland, and Tony Abbott overtaking Kevin Rudd in the satisfaction and preferred PM stakes.

The rest of the week was dominated by chants of cuts, costings, and *Kitchen Cabinet*, with both leaders agreeing to show off their cooking skills with Annabel Crabb.

Both leaders also appeared at the National Press Club, and both gave workmanlike performances, saving their best for the Q and A sessions. No new policies, though.

The other big story of the week was the release of the Coalition's costings, which sparked a bit of biffo between the campaign camps.

Joe Hockey said the budget bottom line would be $6 billion better off under a Coalition government, and announced another $9 billion in savings.

In an unusual move, late on Thursday the Coalition announced that it had posted the following policies on their website:

- The Coalition's policy for Better Child Care and Early Learning.
- The Coalition's policy for Superannuation.
- The Coalition's policy for Foreign Affairs.
- The Coalition's policy for Women.
- The Coalition's policy for a Strong and Sustainable Forestry Industry.
- The Coalition's policy to Enhance Online Safety for Children.
- The Coalition's policy for Healthy Life, Better Ageing.
- The Coalition's policy for Trade.

They are all modest policies. It would seem that with the polls (both public and private) showing a clear victory on Saturday – and desperate to put a cap on spending with the release of the costings – the Coalition had no need to make a song and dance about these policies.

The aged care sector, in particular, was expecting more – with some reports suggesting that aged care leaders had been told in recent briefings that extra funding promises were on the way.

Boring it may have been on the hustings last week, but it is all now a matter for the history books – we have a new Government.

John Flannery

TO COMMENT CLICK HERE

Election health policies found wanting

Ahead of last Saturday's election, the AMA put out a call to the major parties to plug the gaps in their election health platforms.

AMA President Dr Steve Hambleton pointed out that there were lots of votes to be won with positive, forward-looking health policies.

"I set a health policy challenge at the National Press Club in July," Dr Hambleton said.

"We currently have a new set of problems and challenges in meeting the health needs of the Australian community, and they require a new set of solutions – and that is the great task for the major parties.

"Any change must be tested against the reasons we need proper health reform – mainly our increasing burden of chronic disease and our ageing population.

"Proposals should be moving us toward a joined-up, strengthened primary health care system built on team-based solutions."

The Labor policy emphasis was on hospital infrastructure, while the Coalition is concentrated on primary care, especially general practice.

The Greens focused on access to healthcare, public health and environmental health, and had a policy that supports the AMA proposal for an independent panel to assess the health of asylum seekers.

No party produced a comprehensive Indigenous health policy that would provide significant new funding and direction to build on the modest but welcome successes to date of the Closing the Gap strategy.

Dr Hambleton said that the ideal health policy for the election would have combined elements of each of the policies on offer from Labor, the Coalition and The Greens – topped with a 'big bang' Indigenous health policy and a well-articulated approach to dealing with the growing impact of chronic disease.

The big issues missing from the election health policy debate included:

Indigenous Health

There was no significant new funding or direction to build on the modest but welcome successes of the Closing the Gap strategy.

Scrap the Cap

The Government deferred its ill-considered cap on the tax deductibility of self-education expenses, but no party was prepared to dump this policy, which is bad for education, productivity, and the economy, as well as the safety and quality of our health services.

Medical Training

The AMA remains committed to working with the next Government to come up with a long-term policy that supports medical education and training.

Despite the major parties announcing additional intern places in the private sector, which were welcomed, no party tackled the need to better coordinate the medical training pipeline or address the looming shortage of prevocational and specialist training positions as predicted by Health Workforce Australia.

There still needs to be a concerted effort through COAG processes to commit to additional prevocational and specialist training places, including in general practice, with funding to match, in order to ensure that Australia can properly address future community health needs

Chronic Disease

The major parties needed to promise to do more to tackle the impact of chronic disease so that we can keep people well and out of hospital. Current Medicare arrangements impose too much paperwork on GPs and limit access to services for patients with higher health care needs.

The major parties needed to do more to support GPs in caring for these patients by streamlining current Medicare arrangements and by looking to adopt innovative approaches such as the Department of Veterans' Affairs Coordinated Veterans Care program more broadly.

Rural Health

Rural health missed out on the big funding boost it needs to address rural medical workforce shortages.

The AMA/RDAA Rural Rescue Package outlines the funding required to get more doctors into rural and remote Australia, with the right mix of skills to deliver services to these communities

Healthier Australian Families

There was no specific policy announcement from Labor or the Coalition on significant public health concerns around Better Environmental Health (effects of climate change, better standards for clean air, greater health monitoring of non-conventional gas mining projects), Preventing Harms of Alcohol (curbs on alcohol marketing to young people, minimum pricing for alcohol products), or Asylum Seeker Health (independent panel).

...CONTINUED ON PAGE 8

Australian **Federal Election** 2013

Election health policies found wanting

...CONTINUED FROM PAGE 7

Dementia, Aged Care and Palliative Care

We acknowledged and welcomed policy announcements around palliative care and dementia, but they did not go to the key issue of access to medical care.

The major parties needed to release policies that would ensure that people with dementia, those who require palliative care, and older Australians with complex and multiple conditions could receive appropriate medical care. Much more needs to be done to ensure the Medicare arrangements are geared to deal with the increasing numbers of these patients and the need to better manage these patients in the community.

Better recognition of and support for the time that doctors spend assessing patients, organising services and providing support to the patient's family and carers would ensure that quality dementia, palliative and medical care for the elderly is provided inappropriate settings. This would relieve the counterproductive use of acute services.

Affordable Medical Services

There was no policy to immediately restore indexation of MBS patient rebates or to reverse the decision to raise the Extended Medicare Safety Net threshold from 2015 or to restore tax deductibility of out-of-pocket medical and health care gaps.

Authority Prescriptions

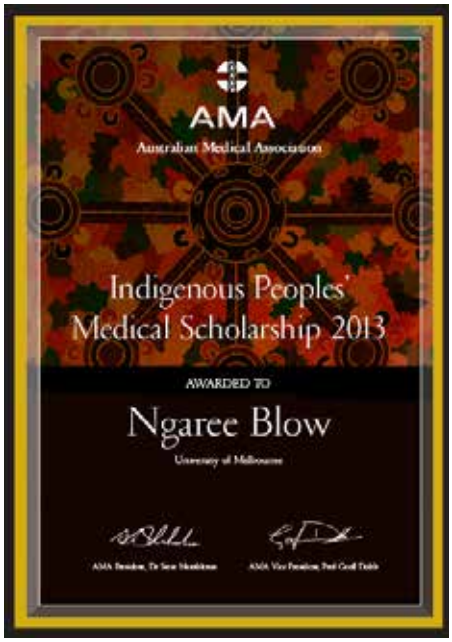
While the major parties mentioned tackling red tape, no party committed to reducing the time wasted by doctors having to telephone the Department of Human Services (DHS) to obtain an authority to write prescriptions for certain PBS medicines. Based on DHS information, up to 25,000 patient consultations are lost while doctors wait for their calls to DHS to be answered.

The AMA will raise these issues in its first meetings with the new Health Minister in the new Government.

John Flannery

TO COMMENT CLICK HERE

Disparity between Indigenous and non-Indigenous Australians a high priority for scholarship winner



A young Indigenous woman who has embraced the fight to close the life expectancy gap between Indigenous and non-Indigenous Australians has won the AMA Indigenous Peoples' Medical Scholarship for 2013.

AMA President Dr Steve Hambleton presented Ngaree Blow, a third year Doctor of Medicine student at the University of Melbourne, the scholarship last week in Melbourne.

Ngaree has traditional connections to Stradbroke Island and her Noonuccal mob, as well as roots in Victoria through the Bangerang people.

Ngaree said she was determined to make a difference to the health inequalities between Indigenous and non-Indigenous Australians.

"I want to work with my community and other Indigenous communities because I am proud of my culture," Ms Blow said.

"I want to see changes in health outcomes to decrease the significant amount of grief and loss for my family and my community, and I want to see greater opportunities for my people in areas such as education.

"Having a healthier community means that there are a lot more opportunities for equality in all aspects of Australian life."

Ngaree is involved with the Australian Indigenous Doctors Association as a student representative, and she is involved with her local rural health club. She also works with The Aspiration Initiative and volunteers with Teachabout, which are both Indigenous education organisations.

Ngaree was originally not accepted into medicine upon completing school. She knew she wanted to be a doctor, so chose to do a Bachelor of Science degree to keep her options open.

While studying Science, her older brother died from a congenital heart disease, an event that re-energised her desire to become a doctor. She was later accepted to study Medicine at the University of Melbourne.

Dr Hambleton said that it was clear from her application for the scholarship that Ngaree holds Indigenous health close to her heart.

"She is passionate about educating others about Indigenous culture and health because she believes the key to improving Indigenous health is to understand the underlying reasons first," Dr Hambleton said.

"It's great to see students like Ngaree, who are the future of medicine in Australia, embracing the fight to close the life expectancy gap between Indigenous and non-Indigenous Australians."

Valued at $9000 for each year of study, the AMA Indigenous Peoples' Medical Scholarship provides support and encouragement for Indigenous students studying medicine.

Dr Hambleton said the scholarship is designed to encourage and support Indigenous students prepare for their careers in medicine, particularly in Indigenous health.

"The AMA acknowledges the unique contribution of Indigenous health professionals to improve health outcomes of Indigenous people," Dr Hambleton said.

"Assisting Indigenous medical students to complete their studies is a positive step toward ensuring there are more Indigenous doctors to serve their communities."

Kirsty Waterford

TO COMMENT CLICK HERE

Defence health services in disarray

The AMA will call on the new Government to commission an urgent audit into the coordination of the delivery of health services to Australian Defence Force personnel by Medibank Health Solutions (MHS).

The call comes amid reports that doctors are experiencing long delays in receiving payment for providing quality off-base care to defence personnel.

The Government announced in February this year that all Defence Health services had been transferred to MHS, with the transition process having been underway since October 2012

Dr Hambleton said that a major AMA survey last year showed that many specialists across the country had refused to sign up to the arrangements being put in place by MHS for the provision of off-base medical services.

"We are concerned that first-rate defence personnel are being provided with second-rate coordination of their health services," Dr Hambleton said.

"It is our understanding that MHS still faces problems in arranging access to off-base specialist services, particularly in areas where major defence facilities are located such as Canberra, Darwin, Townsville and the South Coast of New South Wales.

"We are told that MHS has been forced to use non-contracted specialists as a result.

"It has now emerged that many doctors are not being paid for the provision of services to ADF personnel in a timely fashion.

"The best way to sort out this mess – and deliver to our defence personnel the health services they deserve – is for the new Government to immediately call an audit into the MHS operations," Dr Hambleton said.

Despite MHS coordinating appointments for ADF personnel with medical specialists, MHS is insisting on further evidence to be included on invoices and, since August 1, it has been returning many invoices to doctors and other health professionals unpaid.

According to MHS, as at the end of July, around half of health professionals were submitting "non compliant" invoices.

Dr Hambleton said that MHS has made no effort to work with organisations like the AMA to communicate this issue to the medical profession.

"Many doctors have already been disenfranchised by the contracting arrangements put in place by MHS and it is our valued service personnel who suffer as a result."

John Flannery

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

More clinical academics needed

"Boosting clinical academic numbers would deliver a double benefit to the Australian community"

The AMA last week released its new *Position Statement on Clinical Academic Pathways in Medicine 2013*.

AMA President Dr Steve Hambleton said there is an urgent need to encourage more junior doctors to choose a clinical academic career path.

"Boosting clinical academic numbers would deliver a double benefit to the Australian community," Dr Hambleton said.

"It would increase our capacity for home-grown world-class medical research and it would produce more clinical academic teachers to ensure the next generation of Australian doctors is fully exposed to medical research and clinical training while at medical school.

"Over the past decade, the demise of clinical hospital departments, a decline in academic positions, and an ageing, increasingly part-time workforce have made it difficult for existing clinical academics to continue their research and meet the increased demand for education and training from the growing number of medical graduates coming through the system.

"As a result, junior doctors are less inclined to consider a career in academic medicine because of the challenges associated with career progression, job security, and remuneration.

"We have to turn this around - research experience and incentives to pursue higher degrees should be core components of the medical training experience rather than adjuncts to it," Dr Hambleton said.

In order to promote careers in clinical academic medicine, the AMA recommends that:

- medical students must have an opportunity to experience research in medical school;
- clear and well-articulated pathways must be in place for trainees, senior doctors and clinical academics to pursue a clinical academic career;
- strong mentors and role models must support early career clinical academics;
- flexible entry and exit points must be a key feature of the pathway;
- academic promotion and reward schemes must be developed;
- more funding for clinical academic positions and research is needed to support academic development; and
- support for academic medicine must be embedded in every aspect of the health system.

Dr Hambleton said that Federal and State governments, health departments, universities, medical colleges, and research institutes must work together to develop a strategy to cultivate and retain a well-trained and skilled clinical academic workforce.

The *AMA Position Statement on Clinical Academic Pathways in Medicine* is at https://ama.com.au/position-statement/clinical-academic-pathways-medicine-2013

John Flannery

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Protecting doctors in times of conflict

The AMA Federal Council has adopted the World Medical Association's *WMA Regulations in Times of Armed Conflict and Other Situations of Violence* as formal AMA policy.

The Regulations outline the duties of doctors working in armed conflict and other situations of violence and address the obligations of Governments, armed forces, and others in positions of power to allow health care personnel to fulfil their ethical duties to care for the sick and wounded, and to provide protection for health care personnel and facilities such as hospitals.

The WMA Regulations have taken on greater relevance and significance with health workers being placed in vulnerable and dangerous situations in world trouble spots like Syria.

Last week, a young Syrian surgeon working for *Médecins Sans Frontières* (MSF) was killed in the north of Syria, where he was working at an MSF-run hospital treating victims of Syria's civil conflict.

The AMA believes that doctors must never be prosecuted or punished or killed or injured for complying with their ethical obligations to provide care. Doctors and other health workers must be allowed to provide care to everyone in need, whether civilian or a combatant.

Medical ethics in times of conflict is identical to medical ethics in times of peace.

Doctors must always give someone the necessary care impartially and without discrimination.

All health workers must be protected when they are caring for the sick and the injured during times of conflict.

The AMA supported the Australian Government's push for international support at the G20 Summit in St Petersburg for a medical pact to protect doctors and health workers in Syria.

The Australian plan taken to the G20 involved all sides in the Syrian conflict making a commitment not to target medical personnel, not to block access to doctors, hospitals or emergency care, and not to attack medical facilities.

The document, *WMA Regulations in Times of Armed Conflict and Other Situations of Violence*, is available at https://ama.com.au/position-statement/wma-regulations-times-armed-conflict-and-other-situations-violence-2012

John Flannery

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INFORMATION FOR MEMBERS

HEALTH PROFESSIONALS' CONFERENCE
(formerly known as the Doctors' Health Conference)

DATE: 3rd - 5th October 2013

VENUE: Sofitel Brisbane

The Health Professionals' Health Conference will be held at the Sofitel Hotel in Brisbane from 3rd to 5th October 2013.

The conference recognises the enormous benefits for doctors, nurses, dentists, physiotherapists, pharmacists and other allied health professionals who engage collaboratively in the creation of a healthier workforce.

International speakers from Ireland and Canada and UK will provide insights into how health professionals manage their health across the globe.

There will be preconference workshops on bullying, compassion fatigue and burnout, as well as a session to teach doctors to treat the doctor-patient.

Engage in an interactive inter-professional forum on Mandatory Reporting in Australia with legal and medical experts.

There will also be an interactive session, the Carefactor Workshop for students, with a special student rate available.

beyondblue will also present the results of their mental health survey of doctors and medical student– the latest Australian research on doctors' health.

For more information visit http://www.hphc2013.com.au/

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

New spending of $340m, but cuts on the way, too, *Sydney Morning Herald*, 23 August 2013

AMA President Dr Steve Hambleton said he would oppose any cuts to the planning and analysis done by Health Workforce Australia.

Chemists pressure to prop up profits, *The Daily Telegraph*, 23 August 2013

Consumer groups are warning the major parties not to sign the Pharmacy Guild's letter to support chemist profits at the expense of consumers. Dr Hambleton said it's irresponsible for major parties to sign up to a betrayal of voters.

Michelle's mini-me fashion to fight the fat, *The Daily Telegraph*, 24 August 2013

Dr Hambleton said one in four children were now overweight or obese.

Review of Stilnox over driver safety fear, *Sydney Morning Herald*, 24 August 2013

The FDA is writing guidelines to help drug companies understand what is expected when it comes to studying how drugs may affect next-morning impairment. Dr Hambleton said the implications of the FDA recommendations should be considered.

Soft drinks make kids crazy, *Courier Mail,* 24 August 2013

Half of all Australian children drink one can of soft drink a day and 13 per cent drink three cans or more. Dr Hambleton said parents were even giving babies soft drinks in bottles and sippy cups.

GP Super Clinics diagnosed as a waste of money, *Sunday Telegraph*, 25 August 2013

Doctors have accused the Federal Government of wasting millions building GP Super Clinics in areas they are not needed. Chair of the AMA Council of General Practice Dr Brian Morton said many facilities had been built or proposed in areas where they weren't needed.

Call to set up independent aged-care watchdog, *Sunday Age*, 25 August 2013

Dr Hambleton said an independent aged-care watchdog is a good way of ensuring investigations are thorough and transparent, and the services are sufficiently resourced. He said the public would never have confidence in a system where matters were kept in the dark.

Doctor in the mouse, *The Daily Telegraph*, 26 August 2013

One in five Australians admitted misdiagnosing themselves after relying on health advice from the Internet. Dr Hambleton said while some health websites can be helpful, they should only be used after a doctor delivered a diagnosis.

Men's drug use soars, *The Herald Sun*, 1 September 2013

Young men's thirst for a better body is behind a massive jump in the importation of steroids and hormones. Dr Hambleton said we need to start looking at body image for men as we have for women.

Baby booze shock, *Hobart Mercury*, 2 September 2013

More than one in three pregnant women are putting their babies' brains at risk by drinking alcohol and nearly one in 10 had five drinks in a sitting. Dr Hambleton said the results are surprising and mean that clearly the message is not getting through.

Time to stop grog tweets, *The Herald Sun*, 2 September 2013

Alcohol companies stand accused of using Twitter accounts to target a young and underage audience. Dr Hambleton has previously expressed concern about the use of social media by alcohol companies.

Abbott's baby wins support of doctors, *Hobart Mercury*, 3 September 2013

Doctors and midwives have given the thumbs up to the Coalition's longer paid parental leave scheme. Dr Hambleton said the longer the better.

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AMA IN THE NEWS

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Watching the grass grow, *MX Melbourne*, 4 September 2013

A pro-cannabis party is putting weed in the spotlight in its campaign. Dr Hambleton said there were many negatives with cannabis that required significant caution from a medical perspective.

Radio

Dr Steve Hambleton, ABC News Radio Sydney, 22 August 2013

AMA President Dr Steve Hambleton supports the Coalition's focus to double the PIP teaching incentive. He said it will engage GPs to train and teach students.

Dr Steve Hambleton, 702 ABC Sydney, 26 August 2013

Dr Hambleton said Australians are misdiagnosing themselves after relying on Dr Google. He said people should always consult their doctor before jumping to conclusions.

Dr Steve Hambleton, 774 ABC Melbourne, 3 September 2013

Dr Hambleton discusses his concern over the amount of caffeine consumed by Australians. He said caffeine is getting into our diet at an alarming rate between coffees and energy drinks.

Dr Steve Hambleton, *Radio National Canberra*, 3 September 2013

The Federal Health Department released a discussion paper on regulating the sale of energy drinks in Australia. Dr Hambleton said more regulation is needed.

TV

Dr Steve Hambleton, Channel 10 Melbourne, 26 August 2013

Host Charlie Pickering said a growing number of people are taking babies to see chiropractors to treat anything from asthma to bedwetting. AMA President Dr Steve Hambleton said babies should always be taken to their GP.

Dr Steve Hambleton, SKY News Australia, 29 August 2013

Dr Hambleton described the second death of a competitor at the Perth City2Surf fun run as tragic and disturbing.

Dr Steve Hambleton, Channel 10 Melbourne, 5 September 2013

The Drug Reform Party wants a Royal Commission into drug laws. Dr Hambleton said lives are at risk and there's no easy answers.

TO COMMENT CLICK HERE

AMA in action

AMA President Dr Steve Hambleton at the AMA Indigenous Peoples' Medical Scholarship presentation

University of Melbourne Dean of Medicine Professor Stephen Smith speaks at the presentation of the AMA Indigenous Peoples' Medical Scholarship

AMA President Dr Steve Hambleton has been busy with public engagements and media appearances this past fortnight. He has discussed energy drinks, drug regulation, sexualisation of children, childhood obesity, alcohol intake during pregnancy, Dr Google, chiropractors, fun runs and election health policy promises.

Dr Hambleton also flew to Melbourne to present third year University of Melbourne student Ngaree Blow with the 2013 AMA Indigenous Peoples' Medical Scholarship. Ngaree was heartened to receive the scholarship and wants to reduce the life-expectancy gap between Indigenous and non-Indigenous Australians.

TO COMMENT CLICK HERE

Dr Hambleton getting ready for an interview with *The Project* about drug regulations

Dr Hambleton, Professor Stephen Smith, Ngaree Blow, Dr Stephen Parnis and Dr Mukesh Haikerwal at the AMA Indigenous Peoples' Medical Scholarship presentation

Dr Hambleton was interviewed by *Australian Story* about the sexual health of young adults

Dr Steve presents Ngaree Blow with the Indigenous Peoples' Medical Scholarship

SEPTEMBER HEALTH EVENTS

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

Sun	Mon	Tue	Wed	Thur	Fri	Sat
1 National Blue September Prostate Cancer Awareness Month Childhood Cancer Awareness Month Exercise Your Mood Month National Walk With Me Month National Idiopathic Hypersomnolence Awareness Month Big Red Kidney Walk National Asthma Awareness Week Glow Blow Day Heart Foundation Doorknock Appeal Month	**2** National Jean Hailes Women's Health Week National Eczema Awareness Week National Fertility Week National Child Protection Week	**3**	**4**	**5**	**6** National Footy Colours Day	**7**
8 World Physical Therapy Day National Unity Walk for Parkinson's (QLD, SA, WA) Stay on Your Feet Week (WA)	**9** International Fetal Alcohol Spectrum Disorder Day National Stroke Week	**10** World Suicide Prevention Day National Gynaecological Awareness Day	**11**	**12** National R U OK? Day World Oral Health Day	**13** World Sepsis Day	**14**
15 World Lymphoma Awareness Day Global Mitochondrial Disease Awareness Week	**16** National Dementia Awareness Week	**17** Buzz Day	**18**	**19** National Light the Night Day	**20**	**21** World Alzheimer's Day
22 World Stay in Bed Day	**23**	**24**	**25** National Parkinson Awareness Week	**26**	**27**	**28** National Cancer Council Walk to Work Day World Rabies Day
29	**30** World Heart Day					

TO COMMENT CLICK HERE

Bupa to employ GPs in aged care homes

Bupa has launched an initiative to employ General Practitioners to work in its residential care homes across Australia.

Bupa expects the initiative will improve the health and standard of care of its residents, while reducing medical expenses.

The company already has GPs working at six of its aged care homes and will roll the scheme out to nine additional homes over the next year.

Bupa Care Services Australia Managing Director Louis Dudley said currently one in four aged care residents are admitted to hospital every year and around 30 per cent of the admissions could have been avoided if a GP or other primary health carer was available to assess the resident before a transfer was needed.

"Accessing consistent quality GP services for residents in aged care homes has been a real challenge for aged care providers, and addressing this was central to our plan to help residents live longer, healthier, happier lives," Mr Dudley said.

According to Bupa, under the current aged care model only 30 per cent of residents retain their family GP when they enter residential care.

Bupa Care Services Medical Services Director Dr Daniel Valle Gracia told the *Australian Financial Review* that having a doctor on site is already leading to positive outcomes.

"Because the GPs are spending most of their time in the care home with the residents they get to know the residents, very well [and] the chance of them identifying any change in their condition is much higher, which means we can start treatment sooner," Dr Valle Gracia said.

Visits to the on-site GP will be bulk-billed under Medicare and reimbursements will go back to Bupa to fund some of the GP's salary.

Residents who choose to see the resident GP will be able to book appointments for particular issues, but can visit the GP for monthly check-ups.

Bupa, with the University of Tasmania, will conduct a two-year study into the model of care, looking at indicators such as rates of transfer to hospital emergency departments and falls due to polypharmacy.

A health economist will also measure the cost of the scheme to Medicare, Bupa and the overall health system.

The AMA will closely observe the Bupa model as better access to medical care for older Australians is a core AMA policy.

Kirsty Waterford

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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.

Alarm at the growth of energy drink consumption

The Department of Health has released a discussion paper on the regulation and availability of caffeinated energy drinks amid concerns from health organisations about the adverse medical effects.

The Food Regulation Standing Committee (FRSC), which produced the discussion paper, found that sales of energy drinks in Australia and New Zealand have increased from 34.5 million litres in 2001 to 155.6 million litres in 2010.

The FRSC said that there was some public concern that an increase in the range of products may be associated with an increased dietary exposure to caffeine, and that the increase may have implications for individual and population health, particularly among children and adolescents.

The FRSC found that foods that contain a surprisingly high level of caffeine include chocolate, muffins, and breakfast cereals.

In 2000, the Food Standards Australia and New Zealand (FSANZ) Expert Working Group for Caffeine identified negative effects of caffeine at different doses, including increased anxiety levels at doses of 210mg in adults – equivalent to consumption of three cups of instant coffee – and reduced ability to sleep at doses of 100mg.

AMA President Dr Steve Hambleton called for an increase in energy drink regulations saying excessive consumption of caffeine can lead to insomnia, nervousness, headaches, tachycardia, arrhythmia and nausea.

"Energy drinks are essentially a cocktail of addictive caffeine with sugar," Dr Hambleton said.

"Energy drinks contain a significant amount of caffeine and they're promoted alongside soft drinks.

"Regulations need to be tightened as these products are not intended for children or for pregnant women. Even the manufacturers would agree with that."

A survey released late last week found that one in three teenagers might be consuming the equivalent of 10 instant coffees a day in energy drinks.

Dr Chris Seaton, a paediatric sleep specialist from Westmead Children's Hospital, surveyed 110 patients and found 35 per cent of the teenagers surveyed consumed at least two energy drinks a day.

Dr Seaton said teenagers are limited in getting alcohol and tobacco but there is no limitation on energy drinks. Caffeine in high doses is a toxic substance and there have been a couple of reported teenage deaths related to an overdose.

The Australian Beverages Council said the survey results were grossly misquoted and that most teenagers consumed the majority of their daily caffeine intake from coffee.

Kirsty Waterford

TO COMMENT CLICK HERE

The rise of drug overdoses

Deaths from accidental and prescription medicine overdoses have, for the first time, exceeded the national road toll.

According to figures from the Australian Bureau of Statistics, road accidents in 2011, claimed 1323 Australian lives, compared to 1383 deaths from drug overdoses.

The ABS data also showed that in Victoria, 419 people died of drug overdoses while fewer than 360 died from road accidents.

In 1997, reliable drug overdose data became available and since then road deaths have fallen from around 24 per cent to less than 15 per cent, which is below the 15.2 per cent caused by drug overdoses.

The Association of Needle Exchanges CEO, Mr John Ryan told, the *Herald Sun* that, with more than three in four drug deaths deemed accidental, the revelation that the crossover point between road deaths versus overdoses that had been reached underlined the success in fighting the road toll and the need for greater efforts to tackle rising drug deaths.

"We need to tackle overdoses with the same determination because, at this rate, we may be heading the way of the US," Mr Ryan said.

In an attempt to reduce the number of overdoses and adverse events linked to the drug, paracetamol, supermarkets will be banned from selling large packets of the painkiller.

Starting from September, packets of paracetamol containing more than 21 tablets will only be available in pharmacies.

Eight thousand people a year are treated for paracetamol overdoses. It can result in liver damage and can be fatal in very high dosages.

The Therapeutic Goods Administration (TGA) said it had taken into consideration the changes the US and the UK made by cutting the daily dose recommendations on its paracetamol products.

A spokeswoman for the TGA said it is expected that this decision will result in fewer people requiring medical intervention following a paracetamol overdose, as has been demonstrated in the UK. However, the TGA will not alter its own higher recommended doses for patients in Australia.

Sanja Novakovic

TO COMMENT CLICK HERE

Professor claims pharmacy overpayments

A Melbourne health economist claims that pharmacists are pocketing an average of $340,000 each in overpayments for generic medicines.

Melbourne University Economics Professor Phillip Clark said the suspected overpayments occur when pharmacies receive a set payment from the Government for PBS generic drugs, but then source the drugs at a discount from pharmaceutical companies because of high competition within the market.

The Government currently adjusts the prices it pays pharmacists every 18 months to bring them in line with true prices.

The overpayments are estimated to have totalled $1.8 billion over three years, with pharmacies paid up to 80 per cent more than the market price for generic medicines under the medicine subsidy scheme.

The Government announced last month that it would increase the frequency of reviews from 18 months to 12 months to reduce spending.

Professor Phillip Clark analysed price cuts to hundreds of medicines and said there is much more fat to trim and the Government needs to be tougher.

"Even after the recently announced price changes, we are still paying more than 20 times more than in England," Professor Clark said. "Unfortunately any discounts will continue to flow to pharmacy owners and not to consumers.

"My view is that the cycle could be reduced further, to six months, and then ultimately to three months," Professor Clark told *Australian Doctor*.

The Pharmacy Guild is fighting the proposed change to the review cycle saying price disclosure would be cutting pharmacists' remuneration by about $90,000 a year from 2014 and it would threaten viability, especially in rural areas.

Professor Clark said if the purpose of the policy was to keep pharmacies open in rural areas there are better ways to achieve this, such as targeted subsidies, rather than keeping prices high across Australia.

Kirsty Waterford

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INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

Debate over prostate cancer testing

A senior Melbourne cancer specialist asserts that a push to test men for prostate cancer in their forties wouldn't save lives and would only cause panic.

Associate Professor Ian Haines, from Monash University, said that prostate specific antigen (PSA) tests were doing more harm than good, and were causing many men to have damaging treatment for cancer that was never going to cause them any trouble.

A/P Haines made the claims after experts from the Prostate Cancer World Congress issued a global consensus statement urging men to have a prostate cancer test in their forties. *Australian Medicine* previously reported on the statement – you can read the article at https://ama.com.au/ausmed/prostate-cancer-tests-should-begin-forties

A/P Haines said the doctors behind the statement made about $15,000 on each prostate procedure they performed. He agreed with US doctors who said PSA testing was a public health disaster hijacked by people with commercial interests.

"This is a statement of no value by a self-appointed panel of 10 urologists who have an enormous self-interest," Professor Haines said. "No one should be tested for prostate cancer because the treatment is not effective and does not save lives. We shouldn't test."

But Associate Professor Declan Murphy from the Peter MacCullum Cancer Centre, who helped draft the statement, said it was "completely unreasonable" to say there should be no prostate cancer testing.

A/P Murphy said a US study has found that, if you took PSA tests away, the number of men diagnosed with advanced prostate cancer would triple and the same effect would be seen in Australia.

A draft National Health and Medical Research Council guide on prostate cancer testing found that, for every 1000 men tested, two will avoid death from prostate cancer before 85 years of age because of PSA testing. It also found for every 1000 men tested, 87 men who do not have prostate cancer will have a false positive PSA test that will lead to a biopsy, and a further 24 men will experience a side effect from the biopsy that they consider to be either a moderate or a major problem.

A/P Murphy said many men with low-risk disease were being monitored rather than treated with surgery these days to reduce the harm of over-diagnosis.

Kirsty Waterford

TO COMMENT CLICK HERE

Clearer advice needed on medications and breastfeeding

Mothers who breastfeed are being incorrectly informed to stop breastfeeding or avoid taking medicines because there is a chance they may harm their baby.

Paediatrician and maternal health expert at the Food and Drug Administration Dr Hari Cheryl Sachs said only a small number of medicines are not recommended for breastfeeding mothers.

The American Academy of Paediatrics (AAP) said in a report that mothers should try to avoid certain painkillers, psychiatric drugs, and herbal treatments. However, they can take most prescription drugs without the fear of harming their babies' health.

Most drugs are not found in breast milk at a high level, so it does not make it an issue for the baby's health.

The AAP said in their report that any non-steroidal anti-inflammatory drugs like celecoxib, used for arthritis, and naproxens are compatible with breastfeeding because less than one per cent is excreted into human milk.

The report identifies that a low dose of aspirin is safe to consume while breastfeeding, but high doses have been linked to a rash, blood abnormalities and bleeding. Nicotine replacement therapy is also compatible with breastfeeding, as long as the dose is less than the number of cigarettes usually smoked, because nicotine passes into human milk.

Another issue mothers may not be aware of is herbal medicine. Products such as kava and yohimbe can cause liver damage and infant death. St John's wort can cause colic, drowsiness, or lethargy in infants.

According to Dr Debra Kennedy from the Royal Hospital for Women in Sydney, the main issue is that medical labels are misleading.

"We need to look at more descriptive labels that don't bunch pregnancy and breastfeeding together," Dr Kennedy said.

It is important for medical labels to be clear and precise as organisations such the Australian Breastfeeding Association, whose members are not medically trained and cannot provide correct advice, receive many calls from mothers worried about their medicine intake.

Dr Kennedy said a good example is warfarin, which is not great in pregnancy, but not a problem in breastfeeding, yet if you read the label it is not clear.

A reliable resource for women who have questions regarding taking medication while breastfeeding is the Mother-safe counselling service run by the Royal Women's Hospital in Sydney.

For more information on medications and breastfeeding, visit http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

Sanja Novakovic

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Guide for Practitioners: Notifications in the National Scheme

The Australian Health Practitioner Regulation Authority (AHPRA) has prepared a guide and a series of information sheets to explain to doctors what happens when it receives a notification about a practitioner from the Medical Board of Australia.

The publication, *A Guide for Practitioners: Notifications in the National Scheme*, and the information sheets can be viewed and downloaded at: http://www.ahpra.gov.au/Notifications/Fact-sheets.aspx

The guide for practitioners was written by AHPRA, in conjunction with the various national boards, to explain to health practitioners the complaints process.

AHPRA Chief Executive Officer Martin Fletcher said that the majority of health care practitioners were highly skilled and deeply committed to providing safe care, and acknowledged it could be very confronting for them to be the subject of a notification.

The guide describes what occurs when AHPRA receives a notification from the Medical Board.

This information will complement the direct correspondence that individual practitioners will receive if a notification is made about them.

The AMA first called for the development of the Guide in its submission to the Senate Finance and Public Administrative References Committee in April 2011.

The document sets out the notification process, including the time limits that apply.

It is intended to enable practitioners to better understand the process and what is required of them, as well as providing a means to verify that their matter is being handled in a manner consistent with AHPRA processes.

INFORMATION FOR MEMBERS

Can I prescribe ...?

Most doctors know what the rules are for prescribing medicines in Australia. Or do they?

AMA members frequently ask whether they are able to prescribe in certain circumstances. The most common questions are:

- Can I prescribe for myself?
- Can I prescribe for my family?
- Can I prescribe for someone who isn't directly my patient (a third party)?
- Can I backdate prescriptions?

It is understandable that doctors are uncertain, because there is no simple answer.

Prescribing in Australia is regulated by a range of laws.

For a medicine to be prescribed in Australia, the Therapeutic Goods Administration (TGA) must approve it for sale.

However, each State and Territory has its own laws regulating the prescription of medicines.

These laws determine who can prescribe, which medicines, in what circumstances, in what manner and for what purpose. In addition, specific conditions must be met to prescribe certain classes of medicines, such as some with Schedule 4 and Schedule 8 classifications.

These laws vary in each jurisdiction, so doctors must be careful they understand and comply with the laws in force where they practise.

A further layer of compliance is added for patients to receive a government subsidy under the Pharmaceutical Benefits Scheme (PBS) when they purchase prescribed medicines. Doctors must comply with requirements and restrictions under Commonwealth laws in order to prescribe under the PBS.

Finally, all doctors are bound by the Medical Board of Australia's code of practice – *Good Medical Practice* – as a condition of their registration to practise in Australia.

So can doctors self-prescribe, prescribe for family or for a third party?

Here's what the different laws say:

- Commonwealth, NSW, Queensland, Tasmanian and South Australian laws do not appear to prohibit self-prescribing, prescribing for family or for a third party.
- Doctors practising in Victoria cannot prescribe any S4 or S8 medicines for themselves or for a third party.
- In the Northern Territory, it is slightly more complicated. Doctors cannot self-prescribe S8 medicines or certain restricted S4 medicines, and cannot prescribe for a third party unless the third party is the partner of a patient being treated for Chlamydia who is also likely to have Chlamydia.
- In the ACT, doctors are only prohibited from prescribing for themselves if they are still an intern, or the medicine is a restricted medicine.
- WA law simply prohibits prescribing for the purpose of self-administration.

Good Medical Practice cautions against prescribing for self, family, friends or "those you work with".

It recommends "seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment".

It also advises doctors to "avoid providing medical care to anyone with whom you have a close personal relationship … because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient".

No State or Territory law appears to specifically prohibit backdating of prescriptions. Interestingly, neither does Commonwealth law. While the PBS website states that prescriptions must be not backdated, in fact neither the *National Health Act* nor the *National Health (Pharmaceutical Benefits) Regulations* provide any power to enforce this.

However, all prescribing-related laws require that the prescriber signs and dates prescriptions. It is likely that the intention, while not enforceable, is that the date is contemporary with the signature.

In summary, it is important that you understand the laws in force in the State or Territory in which you practise. Don't rely on hearsay (or this article), because laws change or can be misinterpreted without legal expertise.

If in doubt, check with the drugs and poisons unit in your State/Territory. The TGA maintains up-to-date contact details on its website at: www.tga.gov.au/industry/scheduling-st-contacts.htm.

Information about PBS prescribing rules is available at www.pbs.gov.au.

Good Medical Practice is available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

The AMA's website also maintains a summary of prescribing rules information and links to other sources at https://ama.com.au/node/12303 or you can go to the 'resources' tab on our homepage and look under 'FAQs'.

American Medical News says goodbye

American Medical News (AMNews), the news publication for the American Medical Association, ceased publication this month after 55 years.

Senior management blamed unsustainable financial losses for the move, despite the newspaper's high editorial quality.

The Association said *AMNews* was hit hard by industry-wide trends. Thomas Easley, Senior Vice President and Publisher of periodic publications at the AMA said the newspaper's revenue fell by two-thirds during the last decade.

"Over a 10-year period we were not able to generate an operating surplus for *AMNews*," Mr Easley said.

In 2009, the newspaper's print run was reduced from 48 times a year to 24 times a year and stories were published each weekday on the *AMNews* website, but the change was not enough to turn around the steeply declining revenue.

Mr Easley said making *AMNews* an online-only publication was not feasible because 90 per cent of the newspaper's revenues came from print advertising.

"The challenge we faced was the decline of the business model for print news," Mr Easley said. "This made the decision that we made painful, but in many ways inescapable. This was not attributable to the product, which was still of a very high calibre."

As a result of the closure, 20 full-time reporters, editors, copy editors and art designers, and advertisers lost their jobs.

Senior Vice President, Chief Communications and Marketing Officer Rodrigo Sierra said the Association has other ways to deliver news to physicians.

AMA Wire, a weekly email alert, provides updates about the Association's activities and *AMA Morning Rounds*, emailed each morning at 7am, summarises and links to medical stories getting the most coverage.

The newspaper was first published on 22 September 1958.

Kirsty Waterford

TO COMMENT CLICK HERE

GP MRI referrals: a great way to support general practice

BY **DR BRIAN MORTON**

"Disappointingly, the AMA is excluded from the working group that is developing the clinical guidance for the new items"

Nothing frustrates me more as a GP than seeing my patients inconvenienced unnecessarily because of the rigidities of the heath system.

A case in point is Medicare-funded GP MRI referrals, nearly a decade-long issue.

When a patient presents with symptoms consistent with clinical indications for which an MRI is the most appropriate diagnostic tool, I am not free to refer that patient accordingly unless they are under 16.

Under the present arrangements, my adult patients must first see me for a referral to a specialist. The patient may then need to wait a long time before they can see the specialist. It is likely that they will then have to wait before they can get an MRI scan.

I recently had an elderly patient with severe thoracic pain. While waiting to see her specialist, she suffered complications that required a stay in a public hospital. Had I been able to refer her for an MRI scan on the spot, I could have initiated treatment earlier. Instead, this patient suffered and taxpayers' money was wasted. I could point to similar examples where the present system has delayed appropriate diagnosis and treatment.

Universal access to rebates for MRIs is also an equity issue. The present system discourages lower-income patients from having necessary investigations because they are unable to recover most of the cost of a scan.

Since November 2012, GPs have been able to refer children under 16 years of age for Medicare-funded MRI scans. This followed extensive lobbying by the AMA and we worked closely with the Government on what was a smooth implementation process.

From my experience, there is no doubt that this initiative has given our younger patients better access to care. GPs are managing their patients' conditions more effectively and initiating treatment earlier. When specialist referrals are necessary, the patients have their MRI scan available for their first specialist appointment.

The Department of Health and Ageing is planning to introduce GP-requested MRI items for all patients 16 years and over from 1 November 2013. Disappointingly, the AMA is excluded from the working group that is developing the clinical guidance for the new items.

I have concerns, from what I have seen of the clinical guidance for the proposed items, that the Department will restrict the ability of GPs to use MRI as an appropriate and safer imaging technology in a short-sighted attempt to reduce costs. Common presentations to general practice have been ignored. Assumptions in the clinical guidance are contradictory and discredit the professionalism of GPs.

Let's consider a few facts. MRI is not new technology and has become a normal part of patient care. In many instances, it is the definitive imaging tool for certain conditions.

GP MRI referrals streamline patient care by cutting out unnecessary specialist consultations and ensuring that patients receive the right care at the right time by the right clinician.

GP MRI referrals also enable greater access to care as patients can be referred directly from their GP where clinically appropriate. Patients are saved time and money because they will not have to wait for a specialist appointment and pay the associated gaps. Specialists are available for those who really need their care.

It's a no-brainer that GP-referred MRI can improve patient care and save money. Let's hope that we will soon be able to access the best available technology when caring for all our patients.

TO COMMENT CLICK HERE

Nationals produce a bobby dazzler

BY **DR DAVID RIVETT**

"Certainly some flaws, but compared to the other parties' do-nothing approach to the rural health crisis this is a bloody sound platform, which could be refined into something workable"

I have just torn up my sour opinion piece bemoaning the lack of any sound rural health policy in the election run-up. To my delight, the Nationals have announced a raft of policies which, if they can muscle them through an elected Coalition, will have a huge impact on rural health provision.

They propose -

1. A dedicated Minister for Regional Health to specifically champion the needs of regional patients and health care.
2. Retention of Private Health Insurance rebates to make insurance more affordable, and thus support struggling regional private hospitals and allow them to attract more visiting specialists, reducing the need for rural and regional patients to travel to urban centres for care.
3. Providing funding equivalent to the national average medical benefits funding, by adjusting funding for remoteness. The Nationals will provide increased financial support for doctors who provide health services in regional and remote communities through increased Medicare rebates and scheduled fees on top of regular Medicare billings, which will increase according to remoteness. This sounds very like tier one of the AMA-RDAA Rural Rescue Package.
4. The Nationals will provide guaranteed service levels for key regional hospitals in fields such as maternity, mental health, accident and emergency, and public dentistry. All well and good, but surgery and inpatient medical care, which are the cornerstones of any hospital, seem to have been omitted – presumably by error.
5. Super Clinic money will be redirected to outpatient services in or attached to public hospitals.
6. More trainee positions, internships and residencies in rural hospitals.
7. More funding for regional aged care beds.
8. Ensuring funding for regional health priorities is to be permanent and "ring-fenced". Regional health practitioners will be able to rely on funding support.
9. Flexible practice options are proposed, allowing GPs to choose to be salaried if they choose rather than invest in running and owning practices. They go even further in supporting grants to enable broader provision of services such as allied health, pathology, pharmacology, and radiology in existing practices.
10. They want an immediate review of the ASGC-RA map to more accurately reflect the needs of individual communities. Blithely they suggest such in consult with just the RDAA, ignoring the needs of the vital needs of multiple regional base hospitals who are outside this body's purview.
11. Incentives for allied heath and dentistry to practice regionally will be increased. Bizarrely, it is suggested that, where an area has allied health professionals but no GPs, the Nationals would allow Medicare claims without a doctor's referral. However, such non-recognition of the red-tape pain of a 721-723, which GPs suffer, implies an ignorant view of the Medicare world and could empower very alternative health retreats in remote areas.

Certainly some flaws, but compared to the other parties, do-nothing approach to the rural health crisis this is a bloody sound platform, which could be refined into something workable.

TO COMMENT CLICK HERE

Shining Light on Suppressed Medical Data

BY **AMSA VICE PRESIDENT RICHARD ARNOLD**

Recent research on the dissemination and publication of clinical trials found strong evidence to suggest that more than half of all clinical trials go unpublished and, further, that trials yielding negative results regarding particular treatments are far less likely to be published. A major systematic review (Song et al., 2010) on publication-related biases concluded that "dissemination of research findings is likely to be a biased process". These estimates are made possible by the advent of clinical trial registration, as called for by the international *AllTrials* campaign.

Publication bias not only limits medical knowledge and our understanding of treatment and disease, but has extensive ethical implications for patient safety and exposure to avoidable risk. Above all, the current situation greatly impairs the ability of doctors and other medical professionals to deliver truly informed patient care, perpetuating a flawed reassurance of "evidence-based medicine".

Article 30 of the Declaration of Helsinki, the cornerstone of human research ethics, states that "authors have a duty to make publicly available the results of their research on human subjects … negative and inconclusive as well as positive results should be published or otherwise made publicly available". In January 2013, the *British Medical Journal* underscored these sentiments, stating "the responsibilities of authors are clear. The Helsinki Declaration leaves no room for ambiguity", and that "there is clear and consistent evidence of under-reporting and manipulation of the scientific literature".

A stumbling block for research dissemination is the lack of incentive for companies and researchers to comply with existing mandatory reporting guidelines. For example, it is not unreasonable to suggest that a pharmaceutical company would be financially impacted if a new trial had concluded that their drug was less efficacious or more harmful than originally reported. It is furthermore not unheard of to see such a pharmaceutical company then seek to hide the results or reduce the impact of such a trial.

In 2007, the United States Food and Drug Administration (FDA) introduced regulations under the *FDA Amendment Act* which mandates compulsory publication of a results summary on the ClinicalTrials.gov database for most FDA-approved trials. A 2012 cross-sectional study published in the *British Medical Journal* found a compliance rate of only 22 per cent after four years, with no punitive ramifications for the researchers who failed to comply with the law (Prayle et al., 2012). This follows the failure of previous efforts by the International Committee of Medical Journal Editors to uphold a 2005 promise to publish only registered clinical trials.

Discussion at the Australian Medical Students' Association's (AMSA) Second Council Meeting on the Gold Coast in July quickly led to the formation of consensus: the publication of all clinical trials is crucial to the expansion of the scientific knowledge upon which evidence-based medicine and sound clinical decision-making is based. As such, AMSA believed that all clinical trial results should be registered and published.

The question now arises as to how to move forward on this issue. This issue, while important to medical practitioners and other healthcare professionals, is yet to gain traction in the mainstream media.

It is at this point we are introduced to the *AllTrials* campaign.

"*AllTrials* Registered, All Results Reported" is a joint initiative of the *British Medical Journal*, Sense About Science, James Lind Initiative and the Centre for Evidence-based Medicine that calls upon patient groups and individuals and collectives involved in medicine and research to sign the *AllTrials* petition with the aim of persuading organisations to commit to registering all clinical trials and reporting results from all clinical trials.

At present, the *AllTrials* campaign has in excess of 55,000 signatures globally, and has garnered the support of more than 200 central and influential professional bodies and associations, notably: the Cochrane Collaboration, National Institute for Health and Clinical Excellence, British Medical Association, and the American Medical Student Association.

AMSA was proud to endorse the *AllTrials* campaign earlier this month. We will be following the developments in this field with great interest, and we would encourage the AMA and its members to consider adding their names to the campaign's petition.

More information relating to the *AllTrials* campaign can be found at www.alltrials.net.

Richard Arnold is the Vice-President (External) of the Australian Medical Students' Association and a medical student at The University of Sydney. Follow on Twitter @yourAMSA

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WMA Regulations in Times of Armed Conflict

BY **DR LIZ FEENEY**

Every day we are confronted with images of sickness, death, and destruction arising from armed conflicts around the world. Syria, Egypt, Afghanistan, Iraq, the list goes on.

The global accessibility of personal mobile devices and Internet access allows civilians, soldiers, government officials, media, and others to project harrowing images and personal accounts from inside the violence, anytime, anywhere.

It gets to a point where we want to simply turn off the television, switch off the radio, shut down the computer. It's natural to need a break – to detach ourselves from the violence we see going on half a world away.

But, as doctors, we need to remind ourselves that our colleagues are out there – amongst the violence, the death, the destruction – doing their best to care for the sick and injured in circumstances we can't really imagine unless we've been there.

In 2012, the International Committee of the Red Cross (ICRC) recorded 150 killings and 73 kidnappings of health care personnel during armed conflict and other emergencies in 22 countries.[i] Many more incidents go unrecorded.

Violence against health care personnel also included being beaten, wounded, threatened, and arrested.

The World Medical Association (WMA), of which the AMA is a member, has recently joined the ICRC in a memorandum of understanding – the two organisations will work together to fight violence against patients and healthcare workers and to ensure that healthcare workers are properly trained in their role and responsibilities so they can better manage the dilemmas that arise when violence breaks out.[ii]

Indeed, violence against healthcare workers in areas of armed conflict has been a major focus for the WMA in the past few years. They have spoken out on behalf of medical professionals and healthcare workers working in Bahrain, Egypt, Turkey, and Syria, defending professional independence and integrity, and calling for a cease to the conflicts. They have also spoken out against purported abuse by medical personnel, reminding doctors of their ethical duties to patients and others – to care for the sick and injured impartially and without social discrimination.

The WMA's advocacy position arises from their *Regulations in Times of Armed Conflict and Other Situations of Violence*[iii], a clear, comprehensive policy detailing the rights and responsibilities of medical professionals in times of armed conflict as well as the responsibilities of governments, armed forces, and others in positions of power to ensure doctors and other health care professionals are protected and can provide care to those in need.

The AMA recently adopted the *WMA's Regulations in Times of Armed Conflict and Other Situations of Violence*[iii] to assist our own advocacy in supporting medical and other health care professionals around the world and to remind doctors of their ethical obligations.

I strongly urge you to read the regulations and reflect on the efforts of our colleagues throughout the world who, often at great personal risk, choose to care for the sick and injured during armed conflicts.

The WMA Regulations in Times of Armed Conflict and Other Situations of Violence can be found on the AMA's and the WMA's websites, www.ama.com.au, www.wma.net.

TO COMMENT CLICK HERE

i International Committee of the Red Cross. *Violent Incidents Affecting Health Care. Health Care in Danger. January to December 2012.*

ii World Medical Association. *ICRC and World Medical Association to Work Together for Safer Health-Care Delivery.* WMA Media Release, 26 June 2013.

iii World Medical Association. *WMA Regulations in Times of Armed Conflict and Other Situations of Violence. Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, and edited by the 11th World Medical Assembly, Istanbul, Turkey, October 1957, revised by the 35th World Medical Assembly, Venice, Italy, October 1983, the 55th WMA General Assembly, Tokyo, Japan, October 2004, editorially revised by the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006, and revised by the63rd WMA General Assembly, Bangkok, Thailand, October 2012.*

Research

Study shows diabetes risk factors not being addressed

There is a major discrepancy between how much exercise people think they do and how much they actually do, and younger people are gaining more dangerous weight around their waists than any other age group,a major new study shows,.

The Australian Diabetes, Obesity and Lifestyly Study (AusDiab) also found that living in the most socially disadvantaged areas of Australia doubles your risk of developing diabetes and that depression is nearly twice as common among obese people as those who are not obese.

The study, conducted by the Baker IDI Heart and Diabetes Institute over 12 years, found that despite the serious health risks associated with obesity, high blood pressure and diabetes, Australians are failing to make the necessary lifestyle changes to address the conditions.

AusDiab is the largest Australian study of its kind, tracking 11,000 adult Australians over 12 years to determine how many participants develop diabetes, obesity, and kidney and heart disease.

The research confirmed that obesity remains one of the biggest risk factors for Type 2 diabetes.

The incidence of diabetes is five times higher in people who are obese and twice as high in those who are overweight.

But despite the risks associated with weight gain, 36 per cent of study participants were classified as insufficiently active. And young people aged 25-34 gained more weight and waist circumference during the 12 years compared to all other age groups.

Professor Jonathan Shaw, the study's co-chief investigator, said the trend for greater weight gain among young people is very concerning and suggests Australia still does not recognise the serious health risks of being overweight.

"The health and wellbeing of a whole generation of young Australians is being compromised by a lifestyle rich in energy dense foods and low on physical activity," Dr Shaw said.

"As a community, we need to be prepared to take some tough decisions around these issues.

"It's not impossible. Look at what we've achieved with gun control, smoking cessation and water restrictions.

"On the one hand, we need to encourage and support people to make healthier lifestyle choices by providing the right incentives and, on the other, we need to apply appropriate measures to discourage behaviours that lead to poor health and increased pressures on the health budget."

Participants in the study self-reported that they spent an average of 200 minutes a day sitting. However, a measurement device worn by participants recorded an average 500 minutes a day spent sitting – more than double the time they thought they were sedentary.

Professor David Dunstan, Head of Physical Activity at Baker IDI, said the problem of too much sitting is a relatively new consideration in public health, so it is not surprising that many Australians are not fully aware of just how much time they actually spend seated.

"The findings reinforce the challenge of raising awareness about the hazards associated with too much sitting," he said.

"On a positive note, we are already seeing some organisations take steps to reduce time spent sitting at work through changes to building design and the reshaping of workplace cultures."

The study also found that people with diabetes are at greater risk of depression, cognitive impairment and disability.

The prevalence of depression was 65 per cent higher in people with diabetes, compared to those without, while people with diabetes showed double the rate of cognitive impairment compared to those without diabetes.

And living in the most socially disadvantaged areas of Australia doubles the risk of developing diabetes.

Associate Professor Anna Peeters, Head of Obesity and Population Health at Baker IDI, said that places where there is a higher concentration of junk food outlets and few recreational opportunities tend to be characterised by greater social disadvantage.

"The AusDiab data highlight the extent to which a person's environment makes a contribution to their wellbeing," she said.

Latest figures show that, every day in Australia, about 269 adults over the age of 25 develop diabetes.

Debra Vermeer

TO COMMENT CLICK HERE

Research

Flu vax could halve risk of heart attack

Middle aged people who have the flu vaccine could cut their risk of a heart attack by almost half, a new study shows, prompting a call for authorities to consider routinely vaccinating those aged over 50 with the flu shot.

A University of NSW study found that, for middle-aged people with narrowed arteries, the flu vaccine could lower the risk of a heart attack by 45 per cent.

The research, published in the journal *Heart*, found that influenza may be an unrecognised precursor factor of heart attacks.

"We found influenza vaccination protected significantly against heart attacks," said the study's lead author, Professor Raina MacIntyre.

"The influenza vaccination rate in patients with heart attack was low."

The authors studied the association of influenza and flu vaccination with heart attacks over three winter seasons in Sydney, from 2008 to 2010.

The study found a recent respiratory infection was more common among those patients who had experienced a heart attack, and doubled the risk.

Previous research indicates that infections such as flu might encourage blood to thicken or prompt an inflammatory response in arteries that are already diseased, sparking the development of a blockage.

Professor MacIntyre said, currently, people aged 50 to 64 are not routinely included in national flu vaccination programs, but the research findings have prompted the study authors to call for further discussion on broadening the program.

"Extending the flu vaccination program to 50 to 64 year olds has been a policy debate in the past, but not considered to be cost effective," she said.

"However, prevention of cardiovascular disease wasn't taken into consideration in such estimates."

The researchers are urging increased awareness among GPs and cardiologists of the link between the flu vaccination and heart attack.

"Even if we didn't vaccinate everyone over 50 years of age, influenza vaccination of people with a first heart attack could also have a significant impact, with high rates of subsequent acute coronary events in such patients," said study co-author Dr Pramesh Kavoor, Director of Cardiac Services at Westmead Hospital.

"Doctors should consider vaccination of heart attack patients before hospital discharge and GPs could consider it for those who show other risks associated with heart disease."

The study said cardiovascular disease is the second largest contributor to the disease burden in Australia, accounting for 18 per cent of the total disability-adjusted life years lost.

"As such, even a small effect of influenza vaccination in preventing AMI (Acute Myocardial Infarction) may have significant population health gains," the report said.

In Australia, flu vaccines are currently provided free to people aged over 65, pregnant women, Aboriginal and Torres Strait Islander people, and those with medical conditions that are considered to put them at extra risk.

The study was supported by a grant from the pharmaceutical company, GlaxoSmithKline, maker of one of the flu vaccinations approved for use in Australia, Fluarix.

Debra Vermeer

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New locations in genetic code could help find cause of schizophrenia

Scientists in the US have discovered 13 new locations in our genetic code which could form an important part of the 'jigsaw' when it comes to explaining the cause of schizophrenia, pointing the way to new treatments.

The study from the University of North Carolina (UNC), published online by the journal *Nature Genetics*, estimates the number of different places in the human genome that are involved in schizophrenia.

It shows the large impact of genetic variation on risk for developing the disease.

In particular, the genome-wide association study (GWAS) identifies 22 locations, including 13 newly discovered locations, that are believed to play a role in causing schizophrenia.

"If finding the causes of schizophrenia is like solving a jigsaw puzzle, then these new results give us the corners and some of the pieces of the edges," said study lead author Dr Patrick Sullivan.

"We've debated this for a century, and now we are zeroing in on answers.

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Research

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"This study gives us the clearest picture to date of two different pathways that might be going wrong in people with schizophrenia. Now we need to concentrate our research very urgently on these two pathways in our quest to understand what causes this disabling mental illness."

The study involved a total of more than 59,000 people that began with a sample of 5001 people with schizophrenia and 6243 controls and included analysis of previous GWAS studies and finally replication of single nucleotide polymorphisms (SNPs).

Dr Sullivan, who is Director of the Center for Psychiatric Genomics at the UNC School of Medicine, said one of the two pathways identified by the study is a calcium channel pathway. The other is known as the 'micro-RNA 137 pathway'.

"What's really exciting about this is that now we can use standard, off-the-shelf genomic technologies to help us fill in the missing pieces," he said.

"We now have a clear and obvious path to getting a fairly complete understanding of the genetic part of schizophrenia. That wouldn't have been possible five years ago."

The calcium channel pathway has also been implicated in bipolar disorder and autism, meaning that drugs already approved for therapeutic use in these areas could be "repurposed for the treatment of schizophrenia".

Dr Sullivan and his team concluded their study by proposing a goal for further research in the field.

"The identification of the 2000 loci might be sufficient to confidently and clearly identify the biological processes that mediate risk and protection for schizophrenia," they said.

The study authors said schizophrenia is a mental disorder with a substantial public health impact, including morbidity, mortality, and personal and societal costs.

Collaborators in the study included co-authors from the Karolinska Institute in Stockholm, Sweden, the Stanley Center for Psychiatric Research at the Broad Institute of MIT and Harvard, and the Mt Sinai School of Medicine in New York.

Debra Vermeer

TO COMMENT CLICK HERE

Soft drinks linked to aggression in children – study

A new study shows that soft drinks are linked to aggression, attention problems, and withdrawal behaviour in children, including very young children.

The study, from Columbia University's Mailman School of Public Health, the University of Vermont, and Harvard School of Public Health was published in the *Journal of Pediatrics*.

It found that soft drink consumption at any level was associated with increased aggressive behaviour in children, even after adjusting for other factors like maternal depression, intimate partner violence, and fathers being in jail.

"We found that the child's aggressive behaviour score increased with every increase in soft drinks servings per day," said study lead author Dr Shakira Suglia.

Soft drink consumption has previously been associated with aggression, depression and suicidal thoughts in adolescents, but the relationship has not previously been evaluated in young children.

Dr Suglia and her team assessed about 3000 children aged five, who were enrolled in the Fragile Families and Child Wellbeing Study, which follows a cohort of mothers and children from 20 large US cities.

Mothers reported their child's soft drink consumption and completed a Child Behaviour Checklist based on their child's behaviour during the previous two months.

The researchers found that 43 per cent of the children consumed at least one serving of soft drink per day and four per cent consumer four or more.

Children who drank four or more soft drinks per day were more than twice as likely to destroy things belonging to others, get into fights, and physically attack people. They also had increased attention problems and withdrawal behaviour compared with those who did not drink soft drinks.

The study did not, however, distinguish between what type of soft drinks were consumed, particularly whether they were regular or diet, sugar-sweetened or artificially sweetened, cola or non-cola, and caffeinated or non-caffeinated.

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Research

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Dr Suglia said that, although the study could not identify the exact nature of the association between soft drink consumption and problem behaviours, limiting or eliminating a child's soft drink consumption may reduce behaviour problems.

The research will add further fuel to campaigns by health organisations for governments to restrict soft drink consumption by children or place health warning labels on soft drink bottles.

The Cancer Council, Diabetes Australia, and the Heart Foundation of Australia joined forces in January to call for immediate action by governments, schools and non-government organisations such as sport centres to tackle sugary drinks, which they claim is one of the key contributors to obesity.

Sugary drinks are widely consumed by Australian adults and children. In the 12 months to October 2012, Australians bought 1.28 billion litres of carbonated/still drinks with sugar, with regular cola drinks being the most popular (447 million litres).

The 2007 Australian National Children's Nutrition and Physical Activity Survey found that almost half (47 per cent) of children aged two to 16 years consumed sugar-sweetened beverages, including energy drinks, daily, with a quarter consuming sugary soft drinks daily.

Meanwhile, the Australian Beverages Council criticised calls for soft drink labels to carry warning statements, following the Columbia University study.

The Council's CEO Geoff Parker said the authors did not prove cause and effect.

Mr Parker said that, in accordance with Australian food laws, all beverages clearly state on the back label exactly how much sugar each drink contains and members of the Australian Beverages Council also voluntarily put the amount of kilojoules the products contain on the front of pack label.

"Calls for warning statements regarding the amount of sugar soft drinks contain are not only absurd but lack any credible evidence to support them," he said.

Debra Vermeer

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New discovery could point to treatment for Alzheimer's, Parkinson's

Scientists have identified a way that corrupted, disease-causing proteins can spread in the brain and possibly cause Alzheimer's Disease, Parkinson's Disease and other brain-damaging disorders.

The researchers at Washington University School of Medicine in St Louis discovered a specific type of receptor behind such diseases.

Senior author Dr Marc Diamond says the discovery, published online in Proceedings of the *National Academy of Sciences*, could pave the way to treatment of the disorders, by blocking the receptors, known as haparan sulphate proteoglycans (HSPGs).

"Many of the enzymes that create HSPGs, or otherwise help them function, are good targets for drug treatments," Dr Diamond said in an article on the university's website.

"We ultimately should be able to hit these enzymes with drugs and potentially disrupt several neurodegenerative conditions."

Over the last decade, Dr Diamond, the David Clayson Professor of Neurology at the university, and his team have shown that Alzheimer's Disease and other neurodegenerative diseases spread through the brain in a fashion similar to mad cow disease.

They are caused by misfolded proteins, known as prions.

A protein's abilities to perform basic biological functions are partially determined by the way it folds into a 3D shape. Prions are proteins that have become folded in a way that makes them harmful.

Prions spread across the brain by causing other copies of the same protein to misfold.

Dr Diamond and his colleagues have shown that a part of the nerve cells' inner structure, known as tau protein, can misfold. These corrupted versions of tau stick to each other in clumps within the cells. The clumps then spread from one cell to another.

In the latest study, first author Brandon Holmes, an MD/PhD student, showed that HSPGs are essential for binding, internalising and spreading clumbs of tau.

When he genetically disabled or chemically modified the HSPGs in cell cultures and in a mouse model, clumps of tau could not enter cells, stopping in its tracks the spread of misfolded tau from cell to cell.

Mr Holmes also found that HSPGs are essential for cell-to-cell spread of corrupted forms of another protein, linked to Parkinson's Disease.

"This suggests that it may one day be possible to unify our understanding and treatment of two or more broad classes of neurodegenerative disease," he said.

"We're now sorting through about 15 genes to determine which are the most essential for HSPGs' interaction with tau. That will tell us which proteins to target with new drug treatments."

Debra Vermeer

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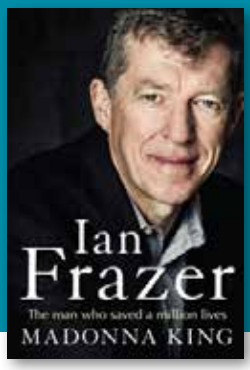
BOOK REVIEW



Ian Frazer: The man who saved a million lives

By Madonna King

ISBN: 978 0 7022 4957 0

Review by Dr Peter Thomas

The unlikely premise of a young and ambitious Scotsman arriving in Melbourne in 1981 to start his life's work in medical research and thirty years later being recognised as "the person who has given science a face" in sport-obsessed Australia is almost mythic. It is a journey comparable to the "log cabin to President" metaphor popular in folklore.

Many doctors could relate to Ian Frazer's early story; academic application, broad outside interests, a supportive family, opportunities (and risks) taken, and occasional luck. Difficult decisions based on family pressures versus career choices will also resonate with many readers.

His years in medical school and later graduate training are unexceptional. Then, feeling the pull of research, he accepts the serendipitous offer of a job at the Walter and Eliza Hall Institute in Melbourne and arrives with wife Caroline in 1981 to start work. His work here bears fruit and in 1985, he takes a position as clinical immunologist at the Princess Alexandra Hospital (PAH) in Brisbane, where this reviewer remembers well the tall Scotsman striding the campus in white lab coat and signature sandals while clutching a tray of test tubes.

His move to conservative Queensland to continue research into sexually related diseases and cancers was, in the political climate of those times, courageous and possibly naïve. It is also counter- intuitive; he replaces the academic excellence and fame of the Melbourne institute for the obscurity of a "broom closet" in the basement of the PAH dialysis building. Inevitably, his comments on the need for publicly funded AIDS clinics in Queensland attract unwanted political attention and threat. He resists and prevails.

He meets his future research partner, Dr Jian Zhou, while on sabbatical leave at Cambridge in 1989 and Jian follows Ian back to Brisbane to collaborate on finding the elusive virus-like particle of the human papilloma virus, the key to making a successful vaccine. Jian and his scientist wife Xiao Yi Sun are rightly afforded generous space in the book. Their dramatic back-story is also outlined. The premature death of Jian at age 42 years in 1999 naturally affects their work and Professor Frazer's ultimate success in discovering and developing a vaccine against cervical cancer owes much to Jian. He memorably acknowledges this during his acceptance speech as Australian of the Year in 2006.

As success in research begins to be recognised, so business partnerships are sought and patents claimed to protect discoveries from circling competitors. Inevitably, with the high monetary stakes on offer, an international legal battle ensues for over a decade, which is only favourably resolved in 2007.

Later events are well -described; philanthropic disbursement of the monies flowing from sale of the vaccine, realisation of a Translational Research Institute in Brisbane, roll-out of the vaccine to third world countries, allegiances with sympathetic politicians to counter misguided opposition to the vaccine, and much more. It is a rich story and Madonna King, a respected Brisbane journalist, tells it well. She skillfully deconstructs complex science and points of law that are a necessary part of the narrative, making the book easily accessible for lay and professional readers alike.

In part a medico-legal thriller, in part a celebration of one man's determination and resolve, the book also serves to remind us of the contribution to medical research and achievements this country has given to the world. To the names of Howard Florey, McFarlane Burnett, Barry Marshall and Robin Warren, John Cade, Struan Sutherland and many more can now be added Ian Frazer.

TO COMMENT CLICK HERE

Sons of a gun – The Barry Brothers

BY **DR MICHAEL RYAN**

You just know when you meet players in the wine game that some are there on the strength of others; with little passion. Then there are those that have this ethereal connected property that underlines their sincerity that stretches back to the terroir from their conception. The former stars burn bright then die out whilst the latter develop in a solid steady crescendo,reaching the pinnacle amongst their peers. The young Barry Brothers of Jim Barry Wines, situated in the Clare Valley, SA, are here for the long haul.

The beginnings of this winery hail back to Jim Barry who graduated from Roseworthy Agricultural College in 1946. He was the 17th recognised scientifically-trained winemaker in Australia. His love of horses and agriculture flourished. He combined sound methods of winemaking techniques, which saw him create many magnificent vintages.

His son, Peter, a marvellous raconteur and ambassador to the industry, also went to Roseworthy and has continued this passion. The grandsons, Sam and Tom are firmly entrenched into the ethos of this wonderful family run business. Tom completes the trifecta with The Barrys the only Australian winemaking family to have three generations of qualified wine makers still active.

A million bottles of wine were made last year using 1500 tonnes of their own estate fruit. The Barrys couldn't afford to sell their fruit as they over-capitalise on this to bring us great wines. To contemplate buying cheaper fruit would be sacrilege. Riesling is the dominating white with some Sauvignon Blanc and Semillon. The Shiraz grape leads the reds with Cabernet Sauvignon fielding strongly along with small batches of Malbec.

Recently I had the fortune of meeting Sam Barry, a holder of an Economics degree, but with a passionate Barry-influenced desire to create great wines. Peter, Tom and Sam are very active travelling promoters as, at the time of writing, Peter was in China, Tom in WA and Sam in Melbourne. Sam acknowledges his brother Tom's winemaking prowess but, as a team, the sum is greater than the parts. Barry Wines are keen to promote that medium to high end wine as the work horse wines continue to build that economic platform. Some of these undervalued wines are in the $50 "GP" range whilst the "Specialist" Shirazes ($200)can hold their heads up alongside the likes of Grange.

WINES TASTED

1. 2012 Florita Clare Valley Riesling

This is fruit from Leo Buring's original iconic vineyards. The Riesling is the flagship white and the immediacy of its release highlights the terroir. A lively pale yellow colour is noted. The nose exudes classic lemon grassy floral notes that link with subtle tropical fruit nuances. The fruit, whilst appearing generous, is corralled by the length of acid. This wine should ensure the return of Riesling as one of the great wines of Australia as its juicy mouth feel and taste is addictive. Have with Tartar Moololaba Tuna and flying fish roe. Cellar until you have no more (>10y).

2. 2012 Barry Bros. Clare Valley Shiraz Cabernet

Great to see the brothers working in tandem. The brighter red colour alludes to the cheery red fruit aromas and hints of currants and spice. The wine is balanced as a medium bodied wine with juicy fruits and subtle structural tannins. The wine zips around the palate and leaves lip smacking pleasantries that just twig the consciousness into thinking, "that is a lot better than you think at $20." 2-3 years cellaring but just enjoy and have with BBQ lamb and rosemary sausages.

3. 2009 McRae Wood Clare Valley Shiraz

Super pedigree (underling to the Armagh) with dense purple colours. The aroma typifies great Clare Valley fruit with red to dark fruits, dates and hints of Asian spices. The palate is all encompassing with a silky fruit driven wine laden with long lived tannins. At $50, this is a keeper. Cellar for 15 plus years. In the meantime, just decant and enjoy with any strong cheddars or lightly seared lamb French cutlet.

4. 2008 The Armagh Clare Valley Shiraz

Named after Irish Settlers, it has long been the poor cousin to Grange. Whilst half the price at $200, it seems to have flailed a little in its desirability. Having drank many of these, it deserves its high end Langton's classification. Dark, dark purple. The nose is layer upon layer of complex fruits, spices, woods, leathers, and florals. It's a heady alluring mix. The palate is young and precocious but ratchets its way across the palate releasing its magic as it travels. Again, decant and enjoy for many decades.

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