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Hope for change of script as Dutton meets AMA

PBS authority system under scrutiny as part of red tape crackdown, p4

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Three Wishes

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

"I am Genie Peter and you have three wishes, but I'm a bit new to this Genie business and they have to be related to health, because my powers only work at the moment across that portfolio"

It's the classic start to a well-rehearsed story, but when Genie Peter appeared before me I still couldn't believe my eyes. My disbelief lasted longer than it should because he didn't look like the usual genie, arising like a wraith from an old and battered brass lamp. Dressed in an immaculate suit, he appeared as I was cleaning my memento of Parliament House.

"Hello", he said, holding out his hand with a firm handshake. "I am Genie Peter and you have three wishes, but I'm a bit new to this Genie business and they have to be related to health, because my powers only work at the moment across that portfolio."

I thought quickly in case he disappeared. My own health is good, so what would make the greatest difference to doctors and their patients in coming years?

"Okay", I said. "Can you ensure there is a medical workforce plan that roughly matches the number of medical graduates to available positions through the training pipeline? We need this to ensure Australia has the fully trained GPs and other specialists we need in the future, and to avoid wasting the expensive investment we have made in medical graduates."

"That sounds reasonable and makes sense", said Genie Peter, "but I'll need to work with other health genies from around the country and that can be hard."

"This is really important", I said. "Without a well trained medical workforce it will be hard to deliver the medical services Australia needs in the future."

"Right", said Genie Peter. "Your wish is granted and we'll give it a really good crack. I hope your second wish is a bit easier."

"It is", I said. "Can you please remove the $2000 cap on tax deductions for education expenses? Doctors need to continually update their knowledge and skills. It is a requirement for them to maintain their medical registration so they can continue to work, so it is an essential business expense. But more importantly, it is so their patients get up to date diagnoses and treatment. Of course, it is not just medicine that is affected, but all health professions and the Australian workforce as a whole. Surely the Prime Genie doesn't want Australia to be known as the dumb and dumber country? Also, the $2000 cap would batter Australia's education and conference industries. The cap has already been deferred by the previous Treasurer, Genie Chris, to 1 July 2015, so that gives plenty of time to review the regulations on tax claims, but the cap should go."

Genie Peter paused for a moment. "I'm not sure this is strictly about health, but I can see that it will impact on health services and all health professionals", he said. "I will need to speak to Genie Joe, but take it that your wish is granted. I hope your last wish is something that lies entirely within my portfolio."

"It is", I said. "It relates to general practice, and since primary care is a Commonwealth responsibility, this is all yours."

I could see he was looking concerned at the prospect of not having anyone else to blame if things went wrong.

"Don't worry", I said. "Australian general practice does a great job, and plays a major part in achieving the outstanding population health outcomes that Australians enjoy. But they are doing it tough. Increased patient expectations, more demand for teaching in general practice, more exacting accreditation standards, increasing business overheads while their patients' rebates from the MBS have fallen from 71 per cent to 49 per cent of the AMA consultation fee."

"I hadn't appreciated it was quite that bad", said Genie Peter, "and anyway, we are planning to review Medicare Locals.

To which I replied, "This isn't just about Medicare Locals or the not-so-super clinics. What about engaging with general practitioners to develop a vision for how Australian general practice should develop over the next five to 10 years? The AMA Council of General Practice has plenty of constructive ideas and, above all this, has the potential, if not to reduce health care spending in real terms, at least to produce some levelling off."

A big smile came over the face of Genie Peter as he said, "That's just what Genie Joe wants to hear. Your suggestion is just a first step, but your wish is granted."

With that, Genie Peter disappeared and I woke up. It was of course just a dream … but it could be much more than that.

TO COMMENT CLICK HERE

Health on the hill

Political news from the nation's capital

Hope on prescription bugbear following Dutton talks

The widely-loathed PBS authority prescription system will be brought into focus by the change of Government following a wide-ranging meeting between AMA President Dr Steve Hambleton and freshly-elected Health Minister Peter Dutton.

While the new Minister stopped well short of promising to scrap the system, under which doctors are required to seek approval from a Department of Human Services bureaucrat before they can prescribe certain medications, Dr Hambleton said Mr Dutton made enough encouraging remarks at the meeting to suggest it is likely to come under scrutiny.

"I pointed out there was a need for a reduction in red tape, and scrapping the system would save six million phone calls a year, something the Minister was very interested in investigating," the AMA President said.

The issue was among several pressing concerns discussed by Dr Hambleton and Mr Dutton during their first major consultation since the Federal election.

During the 9 October meeting, which was also attended by AMA Secretary General Anne Trimmer, Dr Hambleton flagged the AMA's preparedness to contribute to improvements in the design and delivery of health services, as well as raising concerns about inadequate Medicare rebates, increasing education expenses, Government red tape and training shortfalls.

While it is still early days for the Abbott Government, its actions so far reflect the approach it outlined before the election in which it eschewed any plans for major health reform, instead focussing on achieving greater efficiency in spending and setting new priorities that are likely to see some health agencies and programs axed or merged.

In keeping with this focus, at the meeting Mr Dutton reiterated the Coalition's intention to review the Medicare Locals program and the Personally Controlled Electronic Health Record System, as well as taking a closer look at the functions of Health Workforce Australia (HWA).

Dr Hambleton said the AMA welcomed the Medicare Locals review, which is to be conducted according to terms of reference similar to those recommended by the AMA.

He said the AMA was also keen to contribute to the PCEHR review, which is seen as an important opportunity to improve the system and make it much more useful for both patients and doctors.

"The AMA will be making submissions to that review and we would like to see a re-focus on clinical usability and utility for all participants [as a result]," Dr Hambleton said.

Among the other organisations and programs under examination is HWA, which has completed a series of significant reports that have provided information critical to assessing current and future need for medical skills and guiding workforce planning.

Dr Hambleton said that at the meeting with the Minister he and Ms Trimmer emphasised the important contribution the HWA had made to improved workforce planning, and the need for such work to continue.

The AMA President said medical workforce planning and the training pipeline was one of the top issues in health, and extended far beyond the current issues regarding a training bottleneck at the internship level.

"We stressed that the pipeline planning aspect of HWA's work was critical," he said.

Consistent with his emphasis on the importance of GPs, Mr Dutton was also intrigued at the meeting by work around the idea of a "medical home" and the potential for improved care through the creation of chronic disease items on the MBS.

Dr Hambleton said that, in this vein, he used the meeting to alert the Minister to the potential for fragmentation of care as various groups including pharmacists, optometrists and psychologists sought to increase the scope of their practice, such as by acquiring prescribing rights.

"Potential fragmentation of health care is not the solution for helping people, or tackling issues raised by an ageing population or increasing chronic disease," the AMA President said.

But, while Mr Dutton appeared alert to many issues of concern to doctors, he also put the profession on notice that the Government was likely to look closely at medical fees.

In a warning shot for the profession, Dr Hambleton said, Mr Dutton "raised some caution that we need to think about" patient out-of-pocket costs and gap payments.

Adrian Rollins

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Health on the hill

Political news from the nation's capital

Health gets two seats at top table

Health issues appear unlikely to wither because of Prime Ministerial neglect under the Abbott Government.

As freshly-installed Health Minister Peter Dutton noted at a health conference earlier this month, while Prime Minister Tony Abbott's responsibilities might have expanded since he was last in Government, the former Health Minister retains a keen interest in his former portfolio.

"One of the aspects with having a Prime Minister who has been Health Minister is that he is really well informed," Mr Dutton said, adding that virtually every day since he has come to office he has received phone calls from Mr Abbott on health issues, as well as numerous text messages.

This level of Prime Ministerial engagement could have implications for the speed with which health policies and issues are brought before Cabinet for deliberation, and the degree of attention that they receive.

AMA President Dr Steve Hambleton said that, when he was Health Minister in the Howard Government, Mr Abbott had shown himself to be an effective Minister responsive to doctor concerns, not least in his handling of the medical indemnity crisis.

But Dr Hambleton nonetheless cautioned that there was unlikely to be any significant increase in resources for the health system, particularly in the short term.

"The now-Opposition [the ALP] left a lot of fiscal traps behind, and some of them are legislated in place and will need to be legislated away, like the $2000 cap on tax deduction for self-education expenses," he said.

The accuracy of this warning was borne out last week by the response of Mr Dutton to concerns about the effect of the eight-month Medicare rebate freeze on patients, who were likely to face a lift in ou-of-pocket expenses following an increase in recommended GP consultation fees.

"The rebate was frozen by Labor and, given the nation's record debt, it is hard to see how that can be undone," the Minister told News Limited. "Sadly, families are going to be paying for Labor's debt for a long time, including when they go to see their doctor."

Adrian Rollins

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Health gets a king

Ballarat MP and former Health Department bureaucrat Catherine King has been appointed Shadow Minister for Health in the new-look frontbench unveiled by Labor leader Bill Shorten.

Ms King was Parliamentary Secretary for Health and Ageing in the Gillard Government, and her appointment is seen as ensuring there is some experience and continuity in what is regarded as an important portfolio.

Before entering politics in 2001, Ms King was a senior Department of Health and Ageing bureaucrat, serving as Assistant Director in the Department's Population Health Division before becoming Aged Care Director, Injury Prevention, in the Population Health Division.

Ms King fills a vacancy left by Deputy Labor leader Tanya Plibersek who, after serving more than two years as Health Minster, has become Shadow Minister for Foreign Affairs in the Shorten-led Opposition.

In other appointments, Queensland MP Jan McLucas has been made Shadow Minister for Mental Health, Melissa Parke (WA) is Shadow Assistant Minister for Health, and Amanda Rishworth from South Australia is Shadow Parliamentary Secretary for Health.

Adrian Rollins

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Medicare lags further behind as doctors forced to increase fees

"AMA President Dr Steve Hambleton said the rebate freeze was unacceptable, and further inflated the severe discrepancy between what medical services cost to provide, and the rebate the Government was prepared to pay for them"

The fee for a standard GP consultation has been edged $2 higher to $73 in the latest advice issued to doctors by the AMA.

In its annual guidance to members, the AMA has recommended a modest average increase in consultation fees to reflect the rising cost of providing health services, including higher wages, utility charges, rent, insurance premiums and education and training costs.

The rise is set to be felt immediately by some patients, following the previous Federal Government's decision to freeze Medicare Benefits Schedule patient rebates – which are usually indexed in November – through til mid-2014. The measure is expected to save the Commonwealth $664 million.

The delay means the Medicare rebate will remain stuck at $36.30 until July next year, and will account for less than half of the recommended fee for a standard Level B GP consultation.

AMA President Dr Steve Hambleton said the rebate freeze was unacceptable, and further inflated the severe discrepancy between what medical services cost to provide, and the rebate the Government was prepared to pay for them.

"The MBS simply has not kept pace with the complexity or cost of providing high quality medical services," Dr Hambleton said.

In setting the fee increase, the AMA took into account both the movement in wages, which are one of the biggest expenses in providing health services, and increases in other costs such as electricity, equipment, property charges and professional insurance.

The average 2.93 per cent recommended fee increase is less than the 3.19 per cent rise in the Wage Price Index in the 12 months to March, and a little more than the 2.4 per cent lift in the Consumer Price Index in 2012-13.

Dr Hambleton said doctors had kept their fee increases to a minimum, but warned patients faced an increased gap between doctor charges and Government support because of the decision to freeze MBS rebates.

Government figures suggest that patients have so far been largely insulated from any increase in GP charges – in the first three months of the year, the bulk billing rate hit a record high of 82.4 per cent.

Similarly, in the three months to June, just 11 per cent of privately insured patients were required to make a gap payment for in-hospital medical services.

Reflecting this, Australian Institute of Health and Welfare figures show total average patient out-of-pocket expenses increased by just $2 in 2011-12 to $131.

But Dr Hambleton said the ability of doctors to absorb higher costs and continue to bulk bill patients was under severe strain, warning in the *Herald Sun* that the "last time the rebate fell below 50 per cent of the fee we saw a big drop-off in bulk billing".

In the last edition of *Australian Medicine*, AMA Chair of General Practice Dr Brian Morton savaged governments for playing on the goodwill of GPs to wear increased practice costs rather than passing them on to patients.

"Unfortunately, we GPs are our own worst enemy, as we willingly absorb the true cost of providing quality medical care," Dr Morton said. "The profession is seen as a soft target by the Government. The assumption is always that GPs will absorb the costs and continue to bulk bill. This is usually backed by a proud boast about the high rate of bulk billing."

Dr Morton urged GPs to set their fees based on their practice costs and workload.

Dr Hambleton said the AMA applauded those private health insurers who had ignored the Federal Government's Medicare rebate freeze and had "stuck with the tradition of indexing their schedule of benefits on 1 November. These insurers have acted in good faith to minimise the cost impact on their members".

Adrian Rollins

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No drinks before 21: call for debate

AMA President Dr Steve Hambleton has called for a national debate on raising the legal drinking age because of widespread concern about the harm caused by alcohol consumption among young people.

2013 Australian of the Year, former publisher Ita Buttrose, earlier this month proposed that consideration be given to raising the legal drinking age from 18 to 21 years as a way to reduce alcohol-related violence and harm.

Ms Buttrose's suggestion followed a call by some public health experts last year for the drinking age to be raised to 25 years.

While not endorsing any particular age limit, Dr Hambleton said it was important there be a discussion on whether to raise the legal drinking age, and to what level.

The AMA President said international experience showed that raising the legal drinking age to 21 years caused a 15 per cent drop in the incidence of alcohol-related problems, and should be considered.

According to the S*ydney Morning Herald*, around 20 per cent of 16 and 17-year-olds admit to binge drinking, and 13 per cent of deaths among those aged between 14 and 17 years are attributable to alcohol.

The US Centers for Disease Control and Prevention has cited research showing a 16 per cent fall in car crashes involving young people in states that raised the minimum legal drinking age to 21 years in the early 1990s, as well as overall falls in alcohol consumption in those aged 18 to 25 years.

Dr Hambleton said patterns of drinking behaviour developed in the younger years can have life-long effects, leading to adults who are heavier drinkers.

Consideration of raising the legal drinking age has also been fuelled by recent advances in neuroscience showing that the brain does not stop developing until around 25 years, and during this time is particularly vulnerable to the effects of excessive alcohol consumption.

Opponents of any move to raise the drinking age commonly contend that it makes no sense to entrust 18-year-olds with the right to vote and bear arms in defence of the country, but deny them the ability to buy alcohol.

But Dr Hambleton said this was a spurious argument that confused civil rights and responsibilities with public health concerns.

He said the drinking age debate was about the damage caused by alcohol, and how to reduce and prevent it.

Though politicians have so far shown little appetite to tackle the issue, Dr Hambleton said there was widespread concern about drinking among young people.

According to the National Drug Strategy Household Survey, support for raising the legal drinking age to 21 years has increased from around 41 per cent in 2004 to 50 per cent in 2010.

Director of the McCusker Centre on Action on Alcohol and Young People, Professor Mike Daube, told the *West Australian* that a debate on raising the minimum legal drinking age to 21 years was "well worth having", and said a trial of the idea might be "a good option".

"But in the meantime, we should get on with the measures we know work, and for which there is strong public support, such as protecting young people from inappropriate sales and promotion of alcohol," Professor Daube said.

The AMA last year issued a report highlighting the use of social media by alcohol companies to market their products to young people, including children.

Meanwhile, a study released by the Australasian College of Emergency Medicine has found there were more than 4600 'glassing' attacks – where a person is assaulted with a glass object such as a bottle or drinking glass – were notified to the Queensland Injury Surveillance Unit between 1999 and 2011, about 9 per cent of all alcohol-related assault injuries.

The study found that in 72 per cent of cases, the victims were men, and 36 per cent of them were aged between 18 and 24 years.

Significantly, the research showed that glassing attacks were most commonly carried out at home, and 75 per cent involved the use of a bottle.

The authors, Dr Marguerite Sendall, Anthony Laing and Dr Ruth Barker, said the findings showed that glassing was involved in a relatively small proportion of alcohol-related assaults, but highlighted the public health burden of alcohol-related violence in the home.

Adrian Rollins

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E-health records in need of urgent help: GPs

The nation's peak general practice organisations have called for urgent action to address serious shortcomings in the troubled electronic health records system.

At a summit held earlier this month at AMA House, United General Practice Australia (UGPA) identified major problems with the Personally Controlled Electronic Health Record (PCEHR) system that severely undermined its usefulness to both practitioners and patients.

"Currently there is no alignment between consumer registration and meaningful use through engagement of the clinical community and assurance of improvement in patient health outcomes," UGPA, which includes the AMA, the Royal Australian College of General Practitioners, the Australian Medicare Local Alliance and the Australian College of Rural and Remote Medicine, said.

In its statement, UGPA noted the resignation of a number of clinical advisers to the National E-Health Transition Authority (including former AMA President Dr Mukesh Haikerwal), and voiced concerns that opportunities for clinical engagement on the project have since been "less clear".

The GP group called for a profession-led process to improve the PCEHR, including ensuring there was GP input at every point in the system's development, from planning through to implementation, as well as in making sure it was clinically safe and fit for purpose.

UGPA said clinicians also needed to be included in the development of a robust legal and privacy framework for the PCEHR, and to ensure there was secure messaging interoperability.

"E-health and the PCEHR have the potential to transform Australia's health system and provide superior, safer and more efficient health care to all patients," UGPA said. "[But] this potential will only be fully realised if there is meaningful clinical engagement at a grassroots level."

UGPA said it supported the Abbott Government's review of the implementation of the PCEHR, as revealed in the 7 October edition of *Australian Medicine*.

Adrian Rollins

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AMA breaks ground with insurers

The AMA has held talks with the nation's largest health fund on ways the profession and insurers can work more closely together to improve the health system.

AMA President Dr Steve Hambleton met with the Medibank Private (MBP) Board, including Managing Director George Savvides and Medibank Health Solutions Group Executive Dr Matthew Cullen, earlier this month for discussions on opportunities for closer collaboration between the profession and the sector, such as in chronic disease management and continuing professional development.

"We all recognise that there is unlikely to be any huge change in the health system in the next couple of years," Dr Hambleton said. "Activity based funding is yet to be bedded down."

But he said there were many opportunities for private funds like MBP to work with practitioners and practices, such as by assisting practices which were developing their own annual continuing professional development programs.

Last year, MBP's offshoot Medicare Health Solutions (MHS) drew the ire of the AMA after it won the contract to manage on-base health services for Australian Defence Force personnel and unilaterally slashed specialist fees and imposed stringent reporting conditions.

Dr Hambleton said the AMA had made it clear to MBP that it was disappointed with the lack of consultation provided by MHS, "and they [the Medibank Board] recognised that consultation with the AMA would have assisted their decision-making".

Last month, *Australian Medicine* reported that health services for ADF personnel were in disarray, with doctors facing long delays for payments for services provided, and difficulty in many areas in finding specialists to provide off-base services.

The AMA has called for the Abbott Government to commission an immediate audit of MHS and the coordination of health services for Defence staff.

Adrian Rollins

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AMA puts flawed PCEHR on the mend

When his sister was lying unconscious in a hospital intensive care unit, it was driven home to Adelaide GP Dr Chris Moy just how important an accurate electronic health record could be.

"I asked the treating doctor how often do you get a patient's medical history, including the medications they are on, their allergies and diagnoses, and he said 'Never'," Dr Moy recalled.

At the time, he was heavily involved with HealthConnect SA in developing an electronic care planning system for elderly patients.

"A by-product of that was that we were developing a prototype of the electronic health record," he said.

The project was killed off prematurely when the global financial crisis hit in late 2008, bringing an abrupt end to the funding.

But it left an indelible impression on Dr Moy, who saw the potential for e-health to vastly improve health care and potentially save thousands of lives a year, by ensuring practitioners at the point of service had access to vital patient information such as medications, allergies and previous diagnoses.

So it was with mounting frustration and dismay that he, along with much of the medical profession, watched as the Federal Government made basic blunders in building and introducing the Personally Controlled Electronic Health Record (PCEHR).

When he was approached by AMA officials last year to become involved in efforts to address problems with the PCEHR and turn it into something useful for clinicians and patients, Dr Moy was initially reluctant.

But the chance to help realise the potential of e-health to save lives and improve care convinced him to make the commitment.

A little more than 12 months later, he believes the AMA has achieved real progress toward turning the PCEHR from an IT-driven system with little appeal or usefulness for practitioners into something with real and practical benefits for both doctors and patients.

But it hasn't been easy.

"The whole project had gone off track," Dr Moy said. "It was being driven by IT people and programmers, and I could see that they were ballsing it up."

He said they had developed the system with no understanding of how clinicians worked – a huge oversight given that it was doctors (mostly GPs) who would be creating the health records and bearing any risks arising from incomplete or incorrect information.

"I am not an IT person, I am a workflow person, and the program managers and IT people did not understand workflow.

"They did not understand that the way that doctors are going to interact with the PCEHR is through the GP desktop system."

Through his work on the Department of Health and Ageing PCEHR Independent Advisory Council, combined with the efforts of other AMA officials – not least President Dr Steve Hambleton – progress is being made to turn the PCEHR into a practical and useful system.

This has included urging the development of a one-button navigation system for the PCEHR on GP desktop systems; trying to ensure the desktop PCEHR software packages each have a similar look, feel and workflow; promoting the development of demonstration PCEHR models to help doctors familiarise themselves with how it would look and work; and institute a moratorium on the addition of new features until the basics of a practical and useable system for doctors and patients are established.

"We don't need to start again, but we need to make it useable, and our goal is to make sure that clinicians get to develop the workflow of it," Dr Moy said.

He admitted that there was a considerable way to go, but said progress was being made, and urged sceptics to withhold judgement.

"People think I am completely nuts [to have got involved with the PCEHR], but I am still in it because 3500 deaths a year caused by poor [medical] information could be avoided if we get this right,

Dr Chris Moy, Adelaide GP and member of the AMA (SA) Council

as well as millions of adverse events, inappropriate resuscitations and so on."

Among his biggest concerns are the myths and misconceptions held by many regarding the PCEHR, particularly about the ability of patients to alter shared health summaries.

He admitted that, for political reasons, patients and privacy activists had won out over doctors in the tug of war over who would control the health record.

But Dr Moy said this was not the fatal flaw that some claimed it was because – contrary to the myth – patients could not change a shared health summary once it had been created.

"Once a doctor and patient have sat down together and created a shared health summary, the patient can't go back at a later date and decide to delete, say, a herpes diagnosis. Their only option is to delete the entire health summary."

Dr Moy said the creators of the PCEHR had only themselves to blame for such misunderstandings.

"This is a huge myth out there, and the reason why such myths are out there is because there is no demo version out there," he said.

He admits it is likely to be a long and slow process to get the medical profession to accept and embrace the PCEHR, but Dr Moy believes that by making it useful and easy to use, it will gain acceptance – with a massive pay-off in lives saved and unnecessary harm averted.

Adrian Rollins

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Your AMA Federal Council at work

What AMA Federal Councillors and other AMA Members have been doing to advance your interests in the past month

Name	Position on council	Activity/Meeting	Date
Professor Geoffrey Dobb	AMA Vice President	Independent Hospital Pricing Authority Stakeholder Advisory Committee	9/9/2013
Dr David Rivett	AMA Chair of Rural Committee	Independent Hospital Pricing Authority Small Rural Hospitals Working Group	11/9/2013
Dr Steve Hambleton	AMA President	Discussions with peak bodies on clinical input to e-health	11/9/2013
		United General Practice Australia	2/10/2013
Dr Robyn Langham	AMA area nominee for Victoria	Medicines Australia Code of Conduct Review Panel	17/9/2013
		Medicines Australia Code of Conduct Review Panel	14/10/2013
Dr Michael Levick	AMA Member	PCEHR Diagnostic Imaging Stakeholder Workshop	23/9/2013
		PCEHR Pathology Stakeholder Workshop	24/9/2013
Dr Richard Kidd	AMA area nominee for Queensland	PCEHR Diagnostic Imaging Stakeholder Workshop	23/9/2013
Dr Lawrie Bott	AMA Member	PCEHR Pathology Stakeholder Workshop	24/9/2013
A/Prof David Mountain	Craft group nominee for emergency physicians	National Hospital Cost Data Collection Advisory Committee	27/9/2013
Dr Brian Morton	AMA Chair of General Practice	National Residential Medication Chart Reference Group	2/10/2013
Dr Ian Pryor	AMA Member	Medical Services Advisory Committee Review Consultation Committee for ENT Services	4/10/2013

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AMA IN THE NEWS

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

Print/Online

Chiropractic care at just five hours old, *Adelaide Advertiser,* 1 October 2013

An Adelaide chiropractor boasted of manipulating babies as young as five hours old. AMA President Dr Steve Hambleton said any chiropractic care can cause harm and it could stop parents getting proper medical care.

AMA prescribes parental caution on alternatives, *The Australian*, 4 October 2013

The AMA has warned parents to carefully consider whether alternative medical treatments are of any use to their children or in fact pose an increased risk.

NIB to launch healthcare directory, *Sydney Morning Herald*, 4 October 2013

Health insurer NIB is launching a website that rates and compares health professionals. AMA President Dr Steve Hambleton said providing a forum for people to rate practitioners inevitably invites people to berate them.

Minority of practitioners are going out on a limb, *Adelaide Advertiser*, 5 October 2013

Doctors have said a growing number of chiropractors are splitting an industry that is trying to be taken seriously. AMA President Dr Steve Hambleton said for chiropractors to gain credibility they needed to produce evidence for their claims.

Top of the pops getting boozier, *Sunday Mail Brisbane*, 6 October 2013

AMA President Dr Steve Hambleton slammed frequent references to alcohol in popular music, which he warned could glamorise its use. He was commenting on research showing that as many as one in five hit songs have drinking references.

Children's drug link to suicide, *Courier Mail*, 7 October 2013

The AMA has called on paediatricians and psychologists to be cautious about prescribing medication for ADHD after the suicide of a nine year old boy. The AMA said doctors should consider behavioural therapy first.

Call to lift drinking age worth testing, *West Australian*, 9 October 2013

AMA President Dr Steve Hambleton joined a chorus of health experts suggesting that a lift in the legal drinking age from 18 years should be examined.

Botox shots saving teens from ageing, *Sunday Mail,* 13 October 2013

Young people are spending a fortune on botox injections in an attempt to stave off wrinkles and other visible signs of ageing. AMA President Dr Steve Hambleton warned that botox was a neurotoxin that could kill people, and advised young women to protect their skin from the sun instead.

AMA scholarship for Melbourne medical student, *Age*, 14 October 2013

Melbourne medical student Ngaree Blow has won the Australian Medical Association's Indigenous People's Scholarship Award.

Terry White seeks slice of Medicare rebates for pharmacists, *Australian Financial Review*, 15 October 2013

Pharmacy owner Terry White wants pharmacists to be allowed to receive Medicare rebates from the Government for providing health care. AMA President Dr Steve Hambleton said health care providers should work within their levels of expertise.

Radio

Dr Steve Hambleton, 612 ABC Brisbane, 3 October 2013

AMA President Dr Steve Hambleton discussed whether or not a chiropractor damaged or broke a young infant's neck. Dr Hambleton said the AMA thinks chiropractors should not be doing anything with a person so young without quality evidence.

Dr Steve Hambleton, 666 ABC Canberra, 4 October 2013

Dr Hambleton discussed a report about cutting waiting times for elective surgery. Dr Hambleton said it is still too early to tell if a national incentive deal is reducing waiting times or not.

Dr Steve Hambleton, ABC NewsRadio, 4 October 2013

Dr Hambleton discussed the health of health workers. Dr Hambleton said health workers suffer from mental illnesses at the same rate as other members of the society.

Dr Steve Hambleton, ABC NewsRadio, 7 October 2013

Dr Hambleton talked about Australian female GPs being sexually harassed by patients. Dr Hambleton said the AMA is concerned about female GPs, not least because they are now the majority in graduating classes of medical students.

...CONTINUED ON PAGE 14

AMA in action

Dr Steve Hambleton met with politicians, senior business executives, health experts and representatives from other medical organisations during a busy fortnight as AMA President. He met with Medibank Private Managing Director George Savvides, Medibank Health Solutions Group Executive Dr Matthew Cullen and other members of the Board of the nation's largest private health insurer durting a visit to Melbourne. Accompanied by AMA Secretary General Anne Trimmer, he also held a 90-minute meeting with newly-installed Minister for Health and Sport Peter Dutton in Canberra, before both he and Mr Dutton attended a dinner hosted by the Mental Health Council. Dr Hambleton was a participant in the Australia 2.0 forum, an initiative of *The Australian Financial Review* in association with GE that brought together speakers to discuss opportunities and developments in health care, infrastructure, energy and productivity.

Dr Hambleton also presented the AMA's view on topical health issues in numerous interviews for newspapers, radio stations and television programs. He spoke with Sky News about Ita Buttrose's call to raise the legal drinking age to 21 years. Dr Hambleton spoke to a variety of radio stations about the sexual harassment of female GPs, following the publication of research in the *Medical Journal of Australia* showing around half of all women GPs have experienced sexual harassment from patients. He also took to the airwaves to discuss health risks posed by caffeinated energy drinks, and spoke to the BBC about the Australian Government's refusal to pay the Family Tax Benefit A to parents if children were not fully vaccinated.

Dr Hambleton finished his fortnight by attending GP13, the annual conference of the Royal Australian College of General Practitioners', which was held at the Darwin Convention Centre. Ms Trimmer also attended the Conference.

TO COMMENT CLICK HERE

AMA President Dr Steve Hambleton with Health Minister Peter Dutton at Parliament House, Canberra.

Workplace stress takes a major toll on doctor health

Many doctors and medical students have contemplated suicide or are suffering severe psychological distress and burnout, a major investigation into mental health in the medical profession has found.

In a result with major implications for how workload, occupational demands and resources are managed, a study commissioned by the mental health organisation *beyondblue* found 20 per cent of medical students and 10 per cent of doctors had had suicidal thoughts in the preceding 12 months – rates much higher than the broader community - and a quarter of all doctors were likely to have a minor psychiatric disorder, such as mild depression or anxiety.

The study, one of the biggest of its kind ever undertaken, drew on responses from 14,000 doctors and medical students to show that they are far more likely than the general community to be suffering significant psychological distress, but are very reluctant to seek help because of stigma surrounding mental health problems.

AMA President Dr Steve Hambleton said the extent of distress reported by both doctors and medical students was "really disturbing", and underlined the need to break down the stigma surrounding mental illness and improve workplace practices to reduce levels of stress and burnout.

Dr Hambleton told the Health Professionals' Health Conference in Brisbane earlier this month that for a long time discussions about the health of doctors and other health professionals had been taboo but – driven by younger professionals entering the workforce – this was now changing.

"Attitudes are changing," he said. "The AMA has now made the health and welfare of doctors a priority. As health professionals, we have a responsibility to ensure that programs exist to assist our colleagues to access quality health care when they need it."

The *beyondblue* study found that the rate of depression among doctors was similar to that among the broader population, but suicidal thoughts were much more common (24.8 per cent compared with 13.3 per cent), as was the instance of very high psychological distress (3.4 per cent compared with 2.6 per cent).

In a finding that highlights the particularly intense pressure placed on those beginning in the medical profession, the *beyondblue* research found the incidence of very high psychological distress was greatest among doctors aged 30 years or younger.

Young doctors were far more likely to suffer emotional exhaustion, low professional efficacy and a high level of cynicism.

Women doctors also experienced higher levels of distress than their male counterparts. The study found that they were more likely to suffer a mental health disorders, and to have contemplated or attempted suicide.

Dr Hambleton said that although medicine was an extremely rewarding profession, it was also stressful and demanding, and almost invariably doctors paid less attention to their own health than to the wellbeing of others.

"This is a stressful job," the AMA President told Brisbane radio station 4BC. "The work hours for young doctors are quite long, you are wondering about making the wrong decision, you are working with people's lives."

Dr Hambleton admitted there was a tendency among doctors to dismiss thoughts of their own health, and even to share in the stigma attached to mental health problems by the broader community.

"There is a stigma about mental illness, and in the medical profession it is probably even worse, because expectations are so high, and disclosing to a colleague that you are anxious or worried or depressed, you are not sleeping, you actually have a mental illness, is very, very difficult," he said.

...CONTINUED ON PAGE 14

Workplace stress takes a major toll on doctor health

...CONTINUED FROM PAGE 13

Dr Hambleton was critical of mandatory reporting regimes in some states, which he warned deterred people from seeking help.

"The impact of mandatory reporting has resulted in some states seeing dramatic decreases in access to these programs – in Queensland, for example," he said.

"This is a retrograde step [and] the AMA has been vocal in calling for exemptions from mandatory notification requirements for doctors treating colleagues and medical students."

The *beyondblue* researchers identified young doctors as particularly vulnerable to the stresses associated with practicing medicine, particularly long work hours, high demands and heavy responsibilities.

They highlighted the need for greatly increased support for those just embarking on their medical career.

"Levels of cynicism were substantially higher in young doctors in comparison to both pre-clinical and clinical medical students," they said. "This suggests that the transition from study to working may be a particularly difficult time for newly trained doctors, and they may require additional support."

The report found the most common source of stress was trying to balance work demands with personal responsibilities (27 per cent), followed by workload (25 per cent), work responsibilities (21 per cent), long work hours (19.5 per cent) and fear of making mistakes (19 per cent).

Dr Hambleton said the findings underlined the need to promote mental health awareness and support in the workplace.

"There is a common belief in the medical profession that 'we don't get sick, we treat sick people and, besides, we are too busy to go to a doctor'," he said. "Thankfully, attitudes are changing and, driven by young doctors and doctors in training, we are seeing a greater focus among medical practitioners on their own health and the health of their colleagues."

Dr Hambleton said the AMA had made the health and welfare of doctors a priority, and praised steps being taken by the Medical Board of Australia toward funding doctors' health advisory services.

Doctors' health advisory services are available in each State and Territory.

Click on this link (https://ama.com.au/node/3592) for contact details.

Adrian Rollins

TO COMMENT CLICK HERE

AMA IN THE NEWS

...CONTINUED FROM PAGE 10

Dr Steve Hambleton, Radio National Canberra, 7 October 2013

Dr Hambleton discussed the large amount of expensive treatment and hospital care expended in the last weeks of life. Dr Hambleton said that there was a tendency to be optimistic before death.

Dr Steve Hambleton, 4BC Brisbane, 8 October 2013

Dr Hambleton discussed a *beyondblue* report that found many doctors were depressed, contemplating suicide, or suffered exhaustion. Dr Hambleton said being a doctor is a stressful job with long working hours, and young people are under a lot of pressure.

Dr Steve Hambleton, 702 ABC Sydney, 11 October 2013

Dr Hambleton talked about caffeine addiction. Australians drink about four billion cups of coffee a year, according to the Australian Beverages Council, making it the fastest growing beverage on the market.

Dr Steve Hambleton, 666 ABC Canberra, 11 October 2013

Dr Hambleton discussed research by behavioural scientists showing that people suffering symptoms of heart disease were not reporting this to their doctor. Dr Hambleton said early diagnosis could prevent damage to health and death.

Dr Steve Hambleton, 4BC Brisbane, 14 October 2013

Dr Hambleton discussed a plea by the Queensland Chief Medical Officer for parents to have their children vaccinated, following a recent measles outbreak. Dr Hambleton said it is a move he supports.

Dr Steve Hambleton, 3AW Melbourne, 16 October 2013

Dr Hambleton talked about the increasing gap between medical costs and the Medicare rebate. Dr Hambleton said the MBS had not kept pace with the complexity or cost of providing high quality medical services

TV

Dr Steve Hambleton, Today Show, 7 October 2013

Dr Hambleton talked about parents who sought alternative treatment for their children. He said some parents rejected medical care despite the evidence.

TO COMMENT CLICK HERE

Med, Parties and Antipsychotics?

A first-hand account of what it is like to have a serious mental health condition while studying medicine*

** This article has been contributed by a current medical student, on condition of anonymity*

Studying medicine is a roller coaster ride. We have all experienced the amazing highs and lows of studying something that you love, and we have all had to come to terms with the sheer enormity of it all.

My story in medicine is rather similar to most, trying to balance my workload as well as maintaining some semblance of a life outside of the medicine.

Where it differs in one small way is that I have a serious mental health condition that sees me taking meds each night, and participating in regular monthly appointments with my psychiatrist.

For me, my mental health condition and medicine are intricately entwined. In fact, it was the excitement and stress of starting medicine that precipitated my first manic episode, and the subsequent less fun major depressive episode.

Unfortunately, this meant I had to defer first year, as trying to find the right drug is not the easiest task.

I can attest to that, having been tried on about six different meds (with some lovely extra-pyramidal side effects - akithesia is not fun) along the way before finding the right one! But hey, we all have to kiss some frogs don't we?

All up, my journey to health took a good two years, with some hospitalisations, lots and lots of psychiatrist visits, tears (not just mine) and some amazing friends, the family and medical school along for the ride!

However, I'm not writing this to talk about my journey to wellness, but rather about what it is like to have a mental health condition and to be studying medicine.

I hope that perhaps someone who may be at the beginning of their own mental health journey might see that there is some light at the end of the tunnel.

I also hope that my well peers will take something out of this, maybe as future treating doctors, or maybe thinking again about that discussion on advising people with serious mental health conditions against breeding together (yep, this really happened).

> "It saddens me that I have peers that are struggling who are too scared to reach out for help because of a fear of AHPRA (Australian Health Practitioner Regulation Agency) and mandatory reporting"

So what does my mental illness mean for me and studying medicine?

Well, not a huge amount really. I just happen to have a mental health condition and be a medical student. It took me a long time to see this but now it is clearer to me. I don't define myself by my other chronic health condition (asthma), so why should I treat my bipolar any different?

I am on a mood stabiliser that works for me, so I am really not that much different from the usual student.

I may have to be a little bit more careful with my sleep patterns and watching out for triggers, but that's pretty much it. I still go to all the parties, work and basically be a normal person.

I have been really lucky in medicine to have some great friends. Some know about my condition and some do not, but they all like me for who I am.

I really wish I were brave enough to be more open about my bipolar. Unfortunately, the stigma associated with mental health is still very strong and kicking, even in medicine.

I was studying in a PBL room once and hadn't realised that my medication had fallen out of my bag and onto the floor. A fellow student soon found it. Fortunately for me, they didn't assume that the medication was mine. Less fortunate was the subsequent discussion as to who might be the crazy person in our cohort. This was not my finest moment; I went along with the conversation rather than admitting that the medication was indeed mine.

I hope that in the future I will feel comfortable enough to speak honestly in such a circumstance.

I have shared my experiences in the hope that we can promote positive changes in this area.

It saddens me that I have peers that are struggling who are too scared to reach out for help because of a fear of AHPRA (Australian Health Practitioner Regulation Agency) and mandatory reporting.

How can we as a profession even attempt to help our patients deal with the stigma of mental health when so many of our own are suffering in silence?

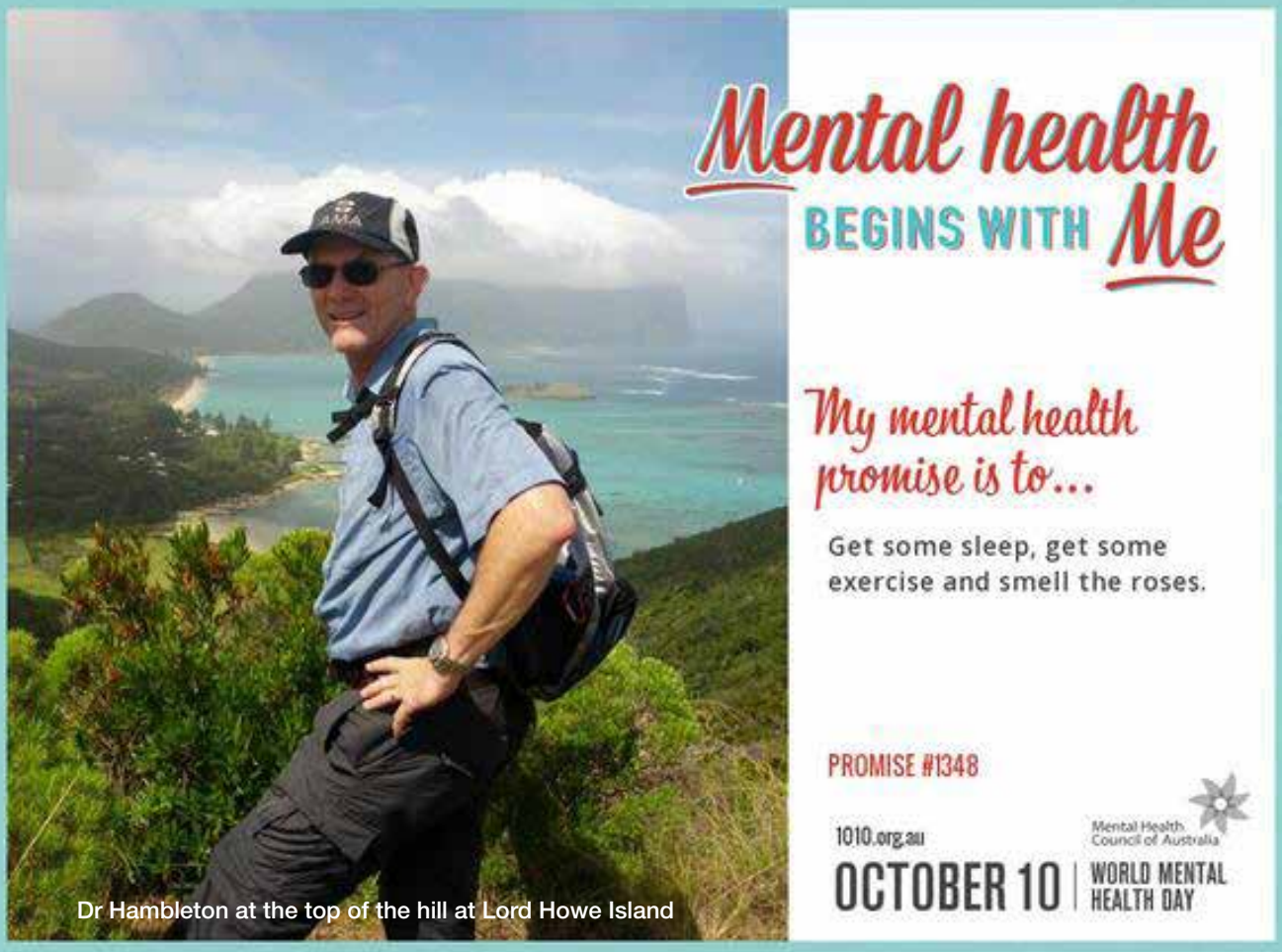
I wish I lived in a world where I could put my name to this article without fear that it could affect my future career.

Let's create a world where people can be open and honest, rather than ashamed, of what is essentially just a medical condition.

I look around me and see some brilliant and passionate people in my course. I strongly feel that together we can play a part in making this a reality.

TO COMMENT CLICK HERE

Doctor, heal thyself



Dr Hambleton at the top of the hill at Lord Howe Island

Doctors can be particularly poor in taking their own advice when it comes to looking after their health, as AMA President Dr Steve Hambleton recently pointed out.

"I took a holiday recently and realised that fitness and me were not on the same page," he told the Health Professionals' Health Conference in Brisbane earlier this month.

"Upon walking up a 'very steep hill' on Lord Howe Island, I took my pulse and found it was 192. If you take the standard formula for maximum heart rate - 220 minus your age - mine is 168.

"Was that a vague chest pain I was feeling? Then and there, my wife made me promise to see my GP – and yes, I will. It's time for a check-up and time to restart the exercise program."

"We need to make sure that doctors are looked after," he said, adding that it was important that doctors make time to do things other than work.

"Work-life balance is important. It could be music, it could be writing, it could be bushwalking, it could be spending time with your family – but it's not all about work.

"It's vital that doctors look after their health. We need to be healthy to offer the best care to our patients, and to experience rewarding and satisfying careers."

Adrian Rollins

TO COMMENT CLICK HERE

Low vax rates raise disease risk

Stubbornly low immunisation rates in parts of New South Wales and Queensland have fuelled concerns that areas of the country are vulnerable to sustained outbreaks of serious diseases including measles and whooping cough.

Figures released by the Council of Australian Governments Reform Council show that although vaccination coverage across most of the country is improving, there are worrying gaps in some areas that threaten to undermine protection against infection.

The report found that infant vaccination rates in areas of NSW where immunisation coverage is low declined in the 12 months to March this year, while Queensland just 82.5 per cent of four-year-olds are fully vaccinated – the lowest proportion in the country.

According to the study, in parts of NSW vaccination rates among children aged between 12 and 15 months have slipped as low as 81.1 per cent, while in South Australia, just 77.1 per cent of Indigenous children in the same age group are fully immunised.

In a more promising result, the report found that vaccination coverage among four-year-olds was at or above 90 per cent in every State or Territory except Queensland (82.5 per cent) and Western Australia (88.9 per cent).

The findings underline concerns that thousands of children are being left vulnerable to deadly diseases by parents who fail to ensure their child's vaccinations are up to date, or who refuse to have their children immunised.

Figures compiled by the National Health Performance Authority earlier this year found almost 77,000 children nationwide were not fully immunised in 2011-12.

Disturbingly, the Authority identified 32 communities where immunisation rates were 85 per cent or less in at least one of the one-, two- and five-year-old age groups.

AMA President Dr Steve Hambleton warned at the time that areas of low vaccination coverage left communities vulnerable to sustained outbreaks of serious diseases.

Dr Hambleton said it was no coincidence that several pockets where there were low vaccination rates were also areas where anti-vaccination groups were active, particularly in northern NSW and south-east Queensland.

Underlining the point, the COAG report showed that the Richmond Valley on the northern NSW coast, where the anti-immunisation Australian Vaccination Network is based, had the lowest immunisation rate in the country.

The threat posed by low vaccination coverage has been highlighted by a United States study that found many areas of California hit by a deadly whooping cough outbreak in 2010 had low rates of vaccination.

The outbreak, the worst in the nation for decades, claimed the lives of 10 infants and left more than 9000 ill.

In the seven years leading up to the outbreak, the proportion of parents claiming non-medical exemptions from vaccination for their children more than tripled, from 0.77 per cent to 2.33 per cent.

The study, published in the journal *Paediatrics*, mapped incidents of whooping cough infections and areas of low immunisation and found that people living in areas where there was cluster of non-medical vaccination exemptions were 20 per cent more likely to contract pertussis that those outside these zones, while those without vaccination were eight times more likely to contract pertussis than those who had been immunised.

This was after researchers had taken into account a range of population characteristics including racial demography, population density, household income, average family size and level of education.

Vaccination has a cumulative effect – the more people in an area who are vaccinated, the less likely it is that an infection will be transmitted through the population. This is particularly important with regard to highly contagious diseases like whooping cough and measles, with estimates that vaccination rates have to reach 94 per cent or higher to ensure herd immunity.

Vaccination expert Paul Offit, of The Children's Hospital in Philadelphia, told *Scientific American* the findings showed that "if more and more people choose not to get a vaccine, then you'll have bigger and bigger outbreaks".

The AMA has raised concerns that the former Labor Government's decision to axe the GP Immunisation Incentives Scheme, under which doctors received payments for ensuring more than 90 per cent of their child patients were fully immunised, has helped reduce vaccination coverage.

But, in an effort to boost vaccination rates, the former Health Minister Tanya Plibersek, earlier this year moved to link eligibility for the $726 Family Tax Benefit Part A supplement to full child immunisation – with exemptions only provided on medical or religious grounds.

Adrian Rollins

TO COMMENT CLICK HERE

Shingles vaccine available for plus 50s

Australians may have to wait until well into 2014 or even later to get subsidised access to the world's first vaccine against the debilitating shingles infection.

Pharmaceutical manufacturer bioCSL has released the first batch of the American-made vaccine Zostavax on the Australian market, allowing adults aged 50 years or more to be vaccinated against the reactivation of the varicella-zoster virus, which causes shingles and can lead to post-herpetic neuralgia.

But the protection comes with a hefty price tag, with a single dose of the vaccine costing up to $250.

While Zostavax has been approved by the Therapeutic Goods Administration for use by people aged 50 years or older, it is yet to be assessed by the Pharmaceutical Benefits Advisory Committee for inclusion in the National Immunisation Program or on the Pharmaceutical Benefits Schedule.

The vaccine is indicated for the prevention of shingles in those aged between 50 and 59 years, and in the prevention of shingles and post-herpetic neuralgia and the reduction of acute and chronic zoster-associated pain in those aged 60 years or older.

A spokeswoman for bioCSL, which is distributing Zostavax in Australia under license from the American manufacturer Merck, said the company was "reasonably early" in the process of having the vaccine registered on the PBS. A submission on the product is being prepared for the PBAC, but the committee is not expected to review the application until March next year.

Meanwhile, those seeking protection from shingles are advised to see a doctor to arrange a private prescription. According to bioCSL, the vaccine is now widely available.

bioCSL said shingles was a common yet incurable condition that would be experienced by one in every two adults by the time they were 85 years.

The risk and severity of the condition increases markedly with age.

It is caused by the reactivation of the varicella-zoster virus that causes chicken pox in children. Following initial infection, the virus lies dormant in nerve roots near the spinal cord, and can reactivate at any time.

The infection often appears as a painful rash or blisters on the skin, and the associated pain can be excruciating.

In addition to the rash, in 50 per cent of cases shingles can lead to post-herpetic neuralgia, a chronic and debilitating form of neuropathic pain that can persist months or even years after the rash has healed.

bioCSL said that more than 97 per cent of Australians had developed antibodies to the varicella-zoster virus by the time they were 30 years of age, indicating almost universal potential to develop shingles among the adult population.

But Associate Professor John Litt of Flinders University was cited by bioCSL as warning that there was no way to predict who would develop shingles, or when.

Associate Professor Litt said that, in the absence of a cure, vaccination against shingles was an important public health measure.

"The impact of shingles on quality of life is comparable to other chronic diseases such as heat failure, type 2 diabetes and depression," he said.

Adrian Rollins

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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.

Many diabetics blind to sight risk

The nation is facing an epidemic of blindness and severely impaired vision because of the prevalence of diabetes, leading researchers have warned.

In a stark assessment of prospects for the estimated 1.7 million people with diabetes, the Centre for Eye Research Australia (CERA) and the Baker IDI Heart and Diabetes Institute have released a report suggesting hundreds of thousands are at risk of going blind in the next decade without regular eye tests.

Report author, CERA executive Dr Mohamed Dirani, warned that almost all people with type 1 diabetes, and 60 per cent of those with type 2 diabetes, would develop some form of diabetic eye disease within 20 years of their diagnosis.

Dr Dirani said diabetics were at far great risk of going blind than the general population, with the likelihood of blindness 25 times greater among diabetics.

Commenting on the launch of the report, Tania Withers, a type 1 diabetic woman from Parkdale, Melbourne, said that she struggled to manage her condition during her teenage years and early adulthood, and neglected to get her eyesight checked regularly.

"At 23 [years], my eyesight started deteriorating and I was diagnosed with diabetic retinopathy," Ms Withers said. "I had not attended regular eye examinations despite being warned by doctors and diabetes educators. Unfortunately, by this stage my retinopathy was advanced and, despite several rounds of laser [treatment] and surgery, I was totally blind within three months."

Adding to the severity of the threat, it has been estimated around 700,000 people have undiagnosed diabetes.

Dr Dirani said diabetic retinopathy currently affected around 300,000 people, and was the leading cause of vision loss and blindness in Australians younger than 60 years of age.

Tragically, he said, much of this suffering could be ameliorated with regular eye tests.

"Diabetic eye disease is a progressive eye disease," he said. "It progresses over time, so early stages of the disease typically go unnoticed."

"The main message is that prevention is key. Individuals with eye disease must have their eyes checked at least once every two years," Dr Dirani said.

He warned that the incidence of diabetes-related blindness and vision loss was likely to increase as the disease itself become more prevalent, with estimates that the number of people with the condition will double by 2025.

"Diabetic eye disease is one of the leading complications of diabetes," he said. "With this increase in prevalence [of diabetes], of course we can expect the prevalence of diabetic eye disease to increase, and that will continue to pose serious personal, public health and economic challenges."

Adrian Rollins

TO COMMENT CLICK HERE

Controversial painkillers stay on the shelves

A painkiller that has been banned in dozens of countries because of safety fears can still be prescribed in Australia, following a decision of the Administrative Appeals Tribunal.

In the end to a long-running case, the Tribunal ruled last month that painkillers containing dextropropoxyphene – which has been associated with fatal overdoses and heart arrhythmia – may not be dispensed unless the prescribing doctor signs a form attesting to the suitability of the drug for that particular patient.

The ruling brings to an end a case that began almost two years ago when the Therapeutic Goods Administration (TGA) banned from sale all painkillers containing dextropropoxyphene, including Capadex, D-Gesic, Doloxene and Paradex, following its withdrawal from the marketplace in the United States, Britain, New Zealand, Canada, Sweden and across the European Union.

In February 2012 the manufacturers of Di-Gesic and Doloxene successfully sought a stay on the ban in the Administrative Appeals Tribunal (AAT), which ordered the TGA to review its decision.

The decision to ban the drugs was reaffirmed by the TGA last September, ruling that the safety risk posed by the drugs was unacceptable.

But the manufacturers disputed the ruling before the AAT and in April this year the Tribunal ruled that the painkillers could remain on the Australian Register of Therapeutic Goods subject to conditions.

The Tribunal made its decision despite acknowledging the safety risks posed by the drug, including that "the difference between a therapeutic amount of products containing [dextropropoxyphene] and a potentially fatal dose was smaller than in many other therapeutic products, and that the risk of accidental overdose, while it could be mitigated, could not be entirely overcome".

Last month the AAT set the conditions under which Di-Gesic and Doloxene can continue to be sold in Australia, including specific requirements for doctors.

When prescribing Di-Gesic and Doloxene, medical practitioners will be required to sign a form confirming that they:

- are aware that the medicine is only approved for use where mild analgesics are not considered adequate;
- have considered the contraindications for the medicines and have explained them to the patient at the time of prescribing;
- have considered any recent changes to the patient's clinical presentation or biochemical status;
- have warned the patient at the time of prescribing about the appropriate use of the medicine; and
- are satisfied at the time of prescribing that the patient's history does not indicate that they are at risk of accidental or intentional self-harm.

The distributors have been directed to ensure that pharmacists do not dispense either medication without first seeing such a form signed by the prescribing doctor or dentists attesting to the suitability of the drug for their particular patient. Furthermore, the distributors must write to all doctors, dentists and pharmacies explaining the new arrangements.

Reflecting continued anxiety about the safety of the drug, the TGA has urged doctors and dentists to "carefully consider" the warnings and contraindications regarding Di-Gesic and Doloxene before prescribing them.

Adrian Rollins

TO COMMENT CLICK HERE

Care urged on drug linked to child suicide

Doctors and parents have been warned to closely monitor the health of children taking the hyperactivity drug atomoxetine, which has been linked to the suicide of a boy and suicidal thoughts in dozens of other youngsters.

The medicines watchdog said it had received reports of 74 psychiatric disorders associated with the use of atomoxetine, including 42 instances of suicidal thoughts – more than half of them in children – resulting in two suicide attempts and one death by suicide.

"The risks of suicidal ideation and behaviour with atomoxetine are well known," the Therapeutic Goods Administration said. "Health professionals should carefully weigh the risks against the benefits of atomoxetine therapy, and patients should be carefully monitored for [suicidal thinking and behaviour], especially in the first few months of treatment and whenever there is a change in dose."

A TGA spokesman said the risk of suicidal thoughts and behaviour among those taking atomoxetine – prescribed to treat attention deficit hyperactivity disorder (ADHD) – was low, and could be minimised by appropriate clinical treatment.

"The TGA's assessment is that the benefits of the medication continue to outweigh the risks," the spokesman said.

The decision by the watchdog to issue the safety reminder has reignited concerns about the extent to which children displaying hyperactive behaviours are being medicated, with claims of a rapid increase in doctors resorting to drugs to alter the behaviour of children.

The Sydney Morning Herald has published data from the Department of Health and Ageing purporting to show that the number of children taking ADHD medication has almost doubled in the past eight years, from 35,000 in 2005 to 69,000 last year.

But the TGA warned caution should be exercised in interpreting the figures, explaining that they were likely to include instances of double-counting of patients if they took more than one medicine in a year.

The TGA spokesman said an analysis of medication rates for ADHD undertaken by a sub-committee of the Pharmaceutical Benefits Advisory Board had found there had been "a small but steady increase" in the prescription of drugs to treat ADHD through the Pharmaceutical Benefits Scheme in recent years.

The TGA said a copy of the report would be released by the end of the year.

Adrian Rollins

TO COMMENT CLICK HERE

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 2012, 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

Gut problem no obstruction to vaccination

Doctors have been told to continue vaccinating children against rotavirus, a severe form of gastroenteritis in babies and young children, despite evidence it increases the risk of a rare form of bowel obstruction.

An investigation commissioned by the Therapeutic Goods Administration has found that the vaccines Rotarix and RotaTeq are associated with instances of intussusception – a rare blockage caused when one segment of the bowel telescopes into another.

Using data gathered from six states and territories over a three-year period, the investigators identified 260 cases of intussusception following vaccination against the rotavirus.

The risk was found to be greatest following the initial dose with the vaccine.

But the study found that the overall incidence of intussusception associated with the rotavirus vaccines was small.

"The risk of intussusception following rotavirus vaccination is estimated as approximately six additional cases among every 100,000 infants vaccinated, or 14 additional cases per year in Australia," the TGA said.

The regulator said that the risk of a minor increase in the incidence of intussusception was worth taking in light of the much larger benefits provided by vaccination against the rotavirus.

"Prior to the introduction of the rotavirus vaccine, there were an estimated 10,000 hospitalisations annually in Australian children under five years due to rotavirus gastroenteritis," the TGA said. "Since the introduction of Rotarix and RotaTeq onto the National Immunisation Program, emergency department visits for acute gastroenteritis in young children have declined and hospitalisations for rotavirus gastroenteritis in the under five-year age group have reduced by over 70 per cent."

Health authorities have recommended that children continue to be inoculated against rotavirus despite evidence the vaccines increase the risk of a rare form of bowel obstruction.

"Based on the established benefits of rotavirus vaccination and the rare occurrence of intussusception, the condition remains rare and this risk is outweighed by the benefits of rotavirus vaccination in preventing rotavirus infections," the regulator said.

Following the investigating, the manufacturers of the vaccines have included extra safety information advising of the risk of intussusception associated with their products.

In addition, the TGA has said doctors should advise parents and carers of the risks and signs of intussusception, and the importance of seeking early medical attention if they suspect it has occurred.

Adrian Rollins

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Evaluation of the Practice Nurse Incentive Program

Call for general practices and Aboriginal health services to participate in an interview to inform the Evaluation

The Practice Nurse Incentive Program (PNIP) was introduced in January 2012 to support practice nurses and Aboriginal health workers working in general practices, Aboriginal medical services and Aboriginal community controlled health services to undertake an expanded and enhanced role in preventive health, chronic disease management and care coordination. It replaced a range of funding arrangements including Practice Incentive Program, Practice Nurse Incentive, and six of the Medicare Benefits Schedule practice nurse items.

The Department of Health and Ageing has contracted KBC Australia, in collaboration with Thinc Health, to undertake an evaluation of the PNIP.

As part of the evaluation, KBC will interview general practices and Aboriginal health services to identify the impact of the changed funding mechanism on the:

- role and function of practice nurses and GPs;
- the business model of practices; and
- the workforce mix within practices and Aboriginal health services.

Practice personnel to be interviewed

Key personnel to be interviewed could include the GP practice principal or medical director, and/or practice manager, CEO of Aboriginal health service, practice nurse manager or senior practice nurse.

Telephone interviews can be undertaken individually or in a group, dependent on the preference of the practice.

It is estimated that interviews will taken about one hour.

For inquiries, or to register your interest, please contact:

Monika Rickli at KBC Australia:
(02) 6361 4000
mrickli@kbconsult.com.au

Observing the boundaries

BY **DR BRIAN MORTON**

"It is important that GPs are provided with the necessary training and skills to take appropriate action and manage the situation"

A number of events in the last few weeks have highlighted that vast array of issues that can effect a doctor's health and wellbeing. One of those issues in particular is the prevalence of sexual harassment of female GPs.

A national survey of general practitioners' experiences of patient-initiated aggression in Australia, conducted early in 2010, found that female GPs and GPs with fewer years of experience were the most likely to have experienced sexual harassment.

This is something that I can personally attest to. When I was in my second year as a GP Registrar I did have the uncomfortable occasion to experience a patient's failure to observe the boundaries of appropriate disrobing. There were also a bevy of married women who visited the surgery far too often with ill-defined problems. The point being that sexual harassment by patients is experienced across our profession, which highlights the need for policies and procedures to prevent it, and skills and strategies to deal with it.

The 2010 survey led to further research focussing on the experiences of female GPs. Of the responding GPs, 54.5 per cent reported experiencing sexual harassment, and almost one in 10 of these reported being sexually harassed more than eight times. The most prevalent behaviours were requests for inappropriate examinations and inappropriate exposure of body parts.

Ensuring a professional relationship with our patients is fundamental to the trust required to care for their health care needs. It is beholden on us to address any behaviour that is unwelcome, and it is equally important that we identify and mitigate any risks to our professional and ethical integrity. The Medical Board of Australia's Sexual Boundaries: Guidelines for doctors can be useful in this regard.

The impact on GPs of experiencing this sort of behaviour - beyond any sort of physical assault - might be poor morale, absenteeism, stress, feelings of decreased competence or anxiety, substance abuse, and loss of job satisfaction.

It is important that GPs are provided with the necessary training and skills to take appropriate action and manage the situation. Equally important is that there is culture within the practice that enables such issues to be brought to the fore.

If a GP is experiencing any patient-initiated sexual harassment or any other inappropriate behaviour, doing nothing is not an option. There are a range of options at your disposal. You can speak up. Tell the patient their behaviour is not acceptable. You may wish to consider getting the patient to sign an acceptable behaviour agreement. Seek advice from your colleagues, your employer, or your professional organisation. Make use of a chaperone. Reassess your consulting style. Change your behaviour. The research indicated that, as a result of experiencing sexual harassment by a patient, two-thirds of female GPs made personal changes or changes to their consulting style. Develop strategies for exiting an uncomfortable situation. If warranted, consider discontinuing care of the patient.

The research is also a reminder to practice owners to have policies and measures in place for dealing with instances of sexual harassment. The practice must have a culture that encourages those feeling harassed to speak up. In addition, as the researchers propose, workforce safety training should cover possible sexual harassment by patients.

Practices, as employers, have an obligation under occupational health and safety laws to inform, instruct, train and supervise all employees, both clinical and non-clinical staff, to ensure their safety and to mitigate any risks to their health, safety and welfare.

Training is an ongoing responsibility. The practice should have appropriate induction policies in place, and everyone in the practice should be kept up to date with safety policies and procedures on a regular basis.

There may not have been such training and policies in place when I was a young GP, but in recent years associations such as the AMA have provided a range of resources to assist practices deal with such issues.

TO COMMENT CLICK HERE

Your career, your choice (but is it really?)

BY **CHAIR DR WILL MILFORD**

Throughout Australia's health system a change is occurring. It is a change that has happened before, as a recent history littered with medical workforce policy failures gives testament to.

The evolution of the workforce balance in most large hospitals is now in a situation where, in junior doctor ranks, the medical workforce is in balance or, at worst, in oversupply.

While this is necessary, with high-level workforce planning predicting that the numbers of medical graduates now are approximately appropriate to meet future community demand, the transition to supplying this demand, beyond producing medical graduates will be challenging. This has been exacerbated by hospitals restricting their recruitment under adverse budgetary pressures.

The dilemma is no longer about numbers. Federal Government policy has overseen dramatic rises in medical student graduates over the last decade. The raw materials are present – now it is a matter of converting them into the finished doctors that the Australian people really need. This means confronting maldistribution: maldistribution in the location of practices, and maldistribution in the choice of specialty.

All medical students had career dreams when they started medical school. Most, driven by altruism, wanted to serve the Australian community, providing health care for those that needed it.

Many had fixed ideas about the way in which these dreams were going to be pursued. Plans to become neurosurgeons, ophthalmologists, or rural 'jack of all trades' general practitioners.

While the dreams and plans are still there, the health system has moved on. Today's graduates face a conundrum: what happens when the community doesn't need them as a heart surgeon or an intensivist?

Do today's graduates still want to serve the Australian community when they are required as a psychiatrist instead of a cardiologist or a general practitioner in Quilpie instead of a surgeon in Toorak?

In policy terms, it is very easy to spout phrases like 'we need more psychiatrists' and 'more doctors for the bush', but how do you convert a junior doctor who has worked their way through medical school with the ambitions of becoming a cardiologist in inner city Melbourne into becoming a psychiatrist in Mildura?

Anecdotally, in some specialties it is already becoming clear that the training pipeline is not matched to community demand. Stories abound of newly 'graduated' specialists either unable to find employment or accepting under-employment due to at-capacity public hospital departments and saturated private markets.

Overlying this is a mismatch in the location of practices, with some graduates prioritising lifestyle decisions to remain in cities over the possibility of greater employment in regional or rural areas. Ultimately, this is the product of personal choice triumphing over the expectation of community service.

This is the crucial issue facing medical training today – how do we balance individual aspiration and ambition with community need? How do we ensure the right mix of incentives and/or recruitment strategies to encourage the uptake of under-subscribed specialties and practice in under-serviced areas?

The answer has to lie in recruitment and career development during medical school. Some approaches are already in place, with a number of workforce measures for rural recruitment implemented with mixed success.

As yet, specialty distribution has not been adequately addressed. Greater exposure and improved experiences in under-subscribed specialties during medical school will be part of the solution. For instance, impending pilots of a community-based internship promise to improve recruitment to general practice.

Indeed, these types of approaches are likely to be the most successful. Co-opting or forcing junior doctors with established career plans can only result in personal dissatisfaction, and has the potential to adversely affect patient care and workforce morale.

The AMA has to continue lobbying on this front, although our position will be fraught. Is it a matter of advocating for the junior doctors facing these challenges, or for the health of the community that will suffer if these problems are not resolved?

Given the inherent contradictions of these positions, making an argument to satisfy both promises to be challenging.

Will is participating in 'Your career, your choice?' panel discussion at the 2013 Prevocational Medical Education Forum in November in Adelaide. A blog (http://www.prevocationalforum2013.com.au/blog/) has been set up to generate pre-conference discussion and raise critical questions.

Follow Will on Twitter (@amacdt) or Facebook (http://www.facebook.com/amacdt)

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Meaningful health system performance information

BY **DR STEVE HAMBLETON**

"It's hardly surprising that performance reporting increasingly tends to recycle information already published by one or more of these bodies, though different presentations and schemas are used for analysis"

A major ongoing focus for the Economics and Workforce Committee's (EWC) work is monitoring and developing policies in relation to the financing and delivery of health care, including public hospital funding and organisational issues.

This includes monitoring how the performance of health care is measured and reported by the range of Government bodies involved.

The Committee has reviewed recent Government reports and the AMA Public Hospital Report Card, and believes there is scope for more meaningful performance information that better reflects the perspectives of clinicians, and can be used for AMA commentary.

The current field for reporting health performance information is crowded.

Government organisations with a direct or indirect stake in performance reporting include the National Health Performance Authority (NHPA), the Independent Hospital Pricing Authority, the National Health Funding Pool Administrator, the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, the Council of Australian Government (COAG) Reform Council and various Commonwealth and State Government departments.

It's hardly surprising that performance reporting increasingly tends to recycle information already published by one or more of these bodies, though different presentations and schemas are used for analysis.

For example, the NHPA has released two series of performance reports (for hospitals and healthy communities) using a small number of specific indicators from the National Performance and Accountability Framework (48 indicators agreed to by COAG under National Health Reform).

NHPA's *Healthy Communities* reports present data in ways that enable comparisons between peer groups of Medicare Local catchments. The most recent report used Medicare claims data and self-reported patient experience and health status to assess performance against criteria including access, urgency, waiting times and cost barriers.

The EWC has noted legitimate concerns that self-reported experience may not be a robust basis on which to objectively measure health care need, or GP waiting times.

Further, because the NHPA *Healthy Communities* website reports performance data against Medicare Local geographical areas, there is scope to wrongly assume the data reflects the performance of Medicare Locals.

But, in fact, the most recent NHPA *Healthy Communities* report provided comparable information on the performance of GPs and specialists - not Medicare Locals.

Nonetheless, it seems likely current approaches to performance reporting will continue for the foreseeable future. This includes defining and reporting primary care system performance by patient surveys on access and affordability, reported by Medicare Local boundaries.

The EWC has identified potential additional measures that the AMA could comment on to bring a new dimension to public hospital performance, such as:

- hospital occupancy rates, rather than bed occupancy;
- unplanned readmission rates;
- mortality rates;
- percentage of staff who rate their hospital as a great place to work;
- simple doctor-to-patient ratios, for example staffing numbers in hospitals; and
- transfers of care (including discharge summaries and discharge planning).

The AMA Council on General Practice is also considering how the performance of Medicare Locals in assisting general practice primary care can be reported by the AMA.

I welcome your views and suggestions on any additional health system performance measures that would be useful for AMA commentary.

TO COMMENT CLICK HERE

Why we should keep Medicare Locals

BY **PROFESSOR STEPHEN LEEDER**

"It would be miraculous if every Medicare Local had worked well, and as miracles are scarce, they have not. But this is no argument for their abolition"

When I was 12 I helped my dad, a teacher, build our modest weatherboard family home at North Epping, NSW, on Saturdays and school holidays. I knew every bearer and joist, every sill and soffit. I happily cut up Tilux for the bathroom and kitchen walls with a handsaw and fibro cutters, amidst clouds of asbestos dust.

Twelve years ago I drove to see the house again. I missed it, retraced and found that it had vanished. Instead, there stood a McMansion. Long time and lots of love to build; gone in an hour with a bulldozer.

Rumours prior to the recent Federal election included one that a Coalition government would demolish Medicare Locals. That rhetoric settled down, but questions persist. Like the National Preventative Health Agency, also under threat http://www.news.com.au/national-news/commonwealth-agencies-to-be-cut-by-abbott-government/story-fncynjr2-1226724733088, these new structures from the past five years of change in the health system took lots of energy to establish but will require no muscle to break up – porcelain vases all. They are ruddy turnstone fledglings asked to fly immediately on hatching to Alaska for summer.

It would be miraculous if every Medicare Local had worked well, and as miracles are scarce, they have not. But this is no argument for their abolition.

Variation is a feasible management challenge here as it is in clinical practice. Many Medicare Locals have not had the time and/or the nurture needed to take firm root. Grumpy, conservative hospital networks – and there are some – with whom Medicare Locals are expected to work, are stony ground. The fault, dear Brutus, is not always with the Medicare Locals.

If I were to pay for you to take a world tour of health services in affluent societies (don't worry, it's not a serious threat), you would find all of them bothered by one thing above all others – how to link hospital and community care more effectively. This is not a fad: it arises from the reality that increasing numbers of older people and people with multiple serious and continuing illnesses require joined-up care that moves from hospital to community and back as easily as crossing a leafy lane.

Well, then, how to make this work?

Recently I attended a conference in London run by McKinsey and Co, a consultancy that has been used by many governments and the private sector to assist in achieving integrated care.

Medicare Locals can – and some are – playing vital role in Australia's response. Three strategies emerge that could be applied with benefit to accelerate our progress:

- pick the low-hanging fruit – scale up successes;
- change the way health care provision is financed; and
- provide incentives for new, more effective and efficient care.

In the case of Medicare Locals and the first point, a review should identify the elements of success among those that have worked well. These elements should then be supported Australia-wide – with financial incentives and sanctions to make them happen.

Second, the fee-for-service model of reimbursement that we have at present is unsuited to long-term, joined up care. The split between Commonwealth and states, private and public, stands in the way of success. This will be hard to negotiate but not impossible.

Third, and linked to this, is the need to build into our health care system of the future a way (as has been done in parts of the US and UK) to support innovation and reward greater effectiveness and efficiency. The reward should come to the service and to the provider. In essence, more effective and efficient care should receive bigger rewards.

These principles are emerging around the world. We would do well to think seriously about them before calling for the 'dozers and the gelly to demolish Medicare Locals.

TO COMMENT CLICK HERE

The suicide bombers among us

BY **DR PAUL ELEFTHERIOU, MEDICAL ADMINISTRATION (RACMA) REGISTRAR, EPWORTH HEALTHCARE**

Suicide was once a romanticised form of ending one's life. For soldiers or freedom fighters alike, suicide was a way to not succumb to the enemy – an honourable means to an end.

I'm not planning on focussing on suicide here – it's a major issue and, unfortunately, a taboo topic.

Instead, I want to bring light to another form of suicide – the slow form, smoking cigarettes.

People who still smoke cigarettes despite decades of health warnings, in-your-face graphic depictions of disgusting sequelae and the information age's access to facts, are slowly committing suicide.

They are slowly killing themselves despite knowing their fate. Slowly killing others close to them. Just like suicide bombers, they take people down with them.

Now, unless you have an intellectual difficulty or are at the stage of adolescence where you have to 'fit in' or need impress the opposite sex (I'm no hypocrite, I too have had a brief affair with a cigarette in the heat of the moment), there is no excuse.

You live in this country, are at an age of decent maturity, you can read or listen to warnings, means don't bloody smoke!

Hence, I've come to the conclusion that those who continue to puff on the cancer sticks are very slowly killing themselves, minute by minute – committing suicide in slow motion.

It also amazes me the amount of times I've given sincere (yet somewhat blunt) advice to patients regarding this dirty habit. I'm actually shaking my head as I write this because I recall the slightly shocked yet guilty look on their faces when I tell them "Smoking is bad for everything…yes it affects every single organ, skin, lungs, brain, arteries, everything!"

My most notable interaction was at a family event when an acquaintance – while puffing on his white/orange suicide trigger – exclaimed in utter disgust that "if they're that bad, I'm quitting now! I had no idea". I humbly pointed out the picture of cancerous lips on his cigarette pack, to which he dramatically threw his cigarette butt onto my innocent lawn – success I thought. No. I hear that a few days later he re-commenced his slow suicide. I thought to myself, he works, he reads and listens, he has multiple health problems, does he live under a rock? Better that he did perhaps. This way he wouldn't be killing anyone around him.

I want to rephrase. Smoking is worse than suicide.

I'd imagine a quick death is relatively painless for the most part, yet I don't condone suicide in any way or form.

The point I'm making is that smoking is worse because it's torture.

I've been fortunate enough to work at Peter MacCallum Cancer Centre, where I was among some of the bravest patients I've ever encountered.

Everyone is wise in retrospect, but dying lung cancer patients (the vast majority of whom were, or continued to be, smokers) all regret the nasty habit.

As the recent Quit campaign memorably put it, "Dying is the least of your worries". The heart-wrenching sight of emaciated terminally-ill patients left me bewildered – how could people still smoke, knowing this could be their fate?

Maybe it should be compulsory for current smokers to wander through some of these wards to take a glimpse of their future – this would be a far better deterrent than tax hikes or plain packaging. Smoking is suicide, but a tortuous one.

I've dealt with countless smoking patients, family and friends who attest that giving up the habit is "really hard!" I know it is. I've studied addiction pathways in the brain, and they're powerful. We know this.

But once again, simple logic applies. If someone told me that this great short-term feeling of taking a puff – that only lasts seconds or minutes – would give me terrible skin, unsightly teeth, horrible lungs, dodgy vessels and, after all that, would inevitably shorten my life by about a decade or more…am I an idiot? Small short-lived 'high' for an immensely negative outcome which just kills you – a few decades of torture then suicide. Resist the temptation.

We as a community need to ban smoking.

Furthermore, the aggressive marketing of cigarettes into developing countries is despicably immoral. We need to shut them down once and for all.

The actions of 'instant' suicide bombers are always condemned, as they cut innocent bystanders' lives short.

We must condemn the 'slow' suicide bombers too, as they also kill more than just themselves.

This has to stop. I hope I can live long enough to see a smoking-free world – before I too am taken out by a smoking suicide bomber.

TO COMMENT CLICK HERE

Members' Forum

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

AMA Chair of General Practice Dr Brian Morton said bulk billing hid the true cost of providing health care. He said it worried him to see registrars who had been discouraged and demoralised by what they saw as the churn of patients through practices, stimulated by bulk-billing. One member shares his view.

Thanks for the article. It's a matter of great interest to me at the moment as I'm going through the process of analysing the viability of opening a new practice in a relatively low socio-economic, outer metropolitan area (am I mad....?)

Part of this involves trying to foretell what might happen with Medicare under a new Government. The particular area I am looking at is relatively under-served (with a number of doctors practising solo coming up to retirement), and an important consideration is the practical, coal-face difficulty in privately billing patients because of genuine financial constraints.

To start up a new practice and speedily grow lists on a private billing basis is, I believe, an unrealistic business plan that is doomed to failure. Obviously, the corporates can ride this growth period out due to size, and the fact is that the GP is simply a loss leader to drive work through profitable areas of the business, such as pathology and radiology. But not all of us want to be such a small cog in a big machine.

The AMA's lists of suggested private fees appear to be pie in the sky, outside of the most affluent areas, which are already well served. Hence, it seems there will inevitably be perpetual inequality in access to primary care across Australia, not just in rural or remote areas, but also in outer metropolitan, low socioeconomic city areas (which do not attract rural incentive payments, or the 10991).

Perhaps the only solution is to have a much more sophisticated weighting of Medicare rebates, based on an individual's income, or maybe postcode, rather than the current one size fits all model, to encourage more doctors to set up in less affluent (and probably more clinically challenging) locations?

Submitted by Dr Richard Newton (not verified)

AMA President Dr Steve Hambleton said chiropractors should be banned from manipulating the skeletons of children until they can prove it helps instead of harms. Many AMA members share their concern.

Remember thalidomide? I do, and that is just one medical disaster. Here is another - the Tuskegee Experiment. Rural black men in the USA [were] deliberately infected with syphilis to study the effects on humans in a controlled experiment that lasted for around 40 years. (www.cdc.gov/tuskegee/timeline).

The list is almost endless if you choose to look. Thousands, if not millions, harmed, maimed and killed by misguided medicine, making a mockery of the lofty principle of, "First do no harm". If Steve Hambleton applies the same rules to medicine that he is seeking to foist on chiropractic, then most of medicine would come to a grinding halt. A 'swallow does not make a summer', Steve!

One adverse incident, that may or may not have been caused by a chiropractic adjustment, does not justify the hysterical attack you are mounting. Historically, medicine has attacked chiropractic when it is, itself, under attack - as it is now by the optometrists, the pharmacists and the nurses. From all those attacks, chiropractic has emerged stronger, more resilient and has actually expanded. It does so, often in spite of itself (it is all too frequently its own worst enemy) because it is seen by the public to have value and is worth sustaining, in much the same way as is medicine. (For the record, I advise that I hold registrations in chiropractic, osteopathy & pharmacy as well as medicine.)

Submitted by Dr Malcolm Rutledge (not verified)

Chiropractors seem to offer short term relief of musculoskeletal problems. However, they are registered practitioners, and need to provide proof that their advice is evidence-based, not just a treatment made up or a hunch.

As for their foray into the field of immunisation - they appear to have no training in this area, and should leave it to those who do.

In the past, they have been critical of GPs who have undertaken post graduate study in musculoskeletal medicine, and who practice manipulations of the spine. The GPs have a solid grounding in anatomy, physiology, biochemistry and orthopaedics, and musculoskeletal medicine is an extension of these disciplines. Since when is immunology a part of the chiropractic degree?

Lastly, I recall with horror a case 25-plus years ago when parents took a baby with Haemophilic meningitis to a chiropractor for neck manipulations, instead of a hospital for antibiotics. Chiropractors were not registered then, and certainly this chiropractor did not have the expertise to recognise a sick baby who needed proper medical attention. The baby died. Chiropractors should stick to what they do best. A few decent court cases may sort this out.

Submitted by Maureen Fitzsimon (not verified)

Chiropractors are also cash obsessed. Getting people to pay thousands to have as many treatments as they need within a timeframe? An effective therapy would only need limited treatment and an effective diagnosis would give the required number of treatments. Try a good physio or a good structural osteopath.

Submitted by canyondave (not verified)

A number of years ago I visited a Chiropractor twice a week for about a year. Till this day I wonder whether I got any real long term benefit out of it. I actually think it may have caused more long term problems than nothing at all.

Submitted by Robert (not verified)

TO COMMENT CLICK HERE

Research

Affairs of the heart kept close to chest

Around one in every five people experiencing symptoms of heart disease refuse to tell their doctor, despite recognising the need for medical attention, a study has found.

Researchers asked more than 600 people, waiting to see their doctor about non-heart related matters, about their levels of depression and anxiety symptoms, current symptoms of undiagnosed heart disease and their intention to talk to their GP about their heart symptoms.

About 20 per cent of patients admitted they had undiagnosed moderate to severe symptoms of heart disease, yet were reluctant to tell their doctor. Interestingly, those with the most severe symptoms were the least willing to talk to their GP about the problem.

AMA President Dr Steve Hambleton told ABC's PM program that there is a golden 24 hours during which 50 per cent of people lose their life from a heart attack.

Dr Hambleton said the first four hours were crucial, and if patients were admitted to hospital during this time doctors could remove blockages of the heart and leave the patient with no damage despite the fact they had just had a heart attack.

Lead researcher, behavioural scientist Dr Coralie Wilson from the University of Wollongong, said heart disease is the leading cause of death in Australia, so understanding the way people behave in seeking treatment is vital.

"Our research showed that patients with symptoms of heart disease that had not yet been diagnosed by a doctor had reduced intention to tell their doctor about these symptoms, even though they also acknowledged that a person with such symptoms should see a doctor," Dr Wilson said.

"As people become unwell their ability to clearly recognise their symptoms and take action becomes diminished."

Dr Hambleton said doctors are trained to read the visual clues of their patients.

"As soon as the patient gets up out of the chair and starts making their way to the door, you're actually starting to assess: What's their gait doing? Are they looking frail? What colour are they? Is there a problem? Are they sweaty and clammy? All those things pass through your mind.

"When we do a general check-up we actually go through something that's called a systems review. The first one on the list is the cardiovascular system: Have you got any chest pain? Have you got any palpitations? Have you had any problems in that area?

"[It is] one of the routines that practitioners are taught, right from early days in student-hood. We've got to go back to those basics and sometimes ask that series of questions."

The research was presented at the Australian Psychological Society's annual conference.

Kirsty Waterford

TO COMMENT CLICK HERE

Anxious musos gets the shimmy, shimmy shakes

Australia's orchestral musicians are often in physical pain and anxious when they perform, according to new research.

University of Sydney psychologists examined 377 members of Australia's eight state and opera orchestras and found more than 80 per cent reported experiencing physical pain severe enough to impair their performance, and 50 per cent reported moderate to severe performance-related anxiety, while 32 per cent had symptoms of depression.

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Research

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Lead author Professor Dianna Kenney said there was a strong relationship between the severity of performance-related pain and music performance anxiety, with those who reported the most severe pain reporting higher music performance anxiety.

Professor Kenney said that music performance anxiety can manifest itself physically as trembling, shaking, elevated blood pressure and heart rate, and cognitively as dread, worry, rumination or catastrophic thinking.

"Seventy-five per cent of the musicians showed the expected relationship between pain and depression," Professor Kenney said. "Those reporting no depression were also more likely to report little to no pain. Those who reported some depression reported higher levels of pain."

In contrast to those musicians who displayed the expected relationship between depression and pain, there was a substantial minority who reported no depression but severe pain, and Professor Kenny said this group warranted closer examination.

"These results suggest some musicians might somatise their pain. This means that they may convert their psychological distress into muscle tension, which leads to physical pain," she said.

"The implication of these findings is that physically-based treatments of performance-related musculoskeletal pain that do not address associated anxiety and depression might not prove to be effective."

The findings were published in *Psychology of Music.*

Kirsty Waterford

TO COMMENT CLICK HERE

Even light smokers court early death

Risk of premature death from smoking is higher than previously thought, with smokers who limit themselves to just a few cigarettes a day no better off than the morbidly obese when it comes to the risk of death.

In a finding that underlines the damage even a few cigarettes a day can cause, a large long-term Australian study has found that the risk of death among those who smoke up to an average of 10 cigarettes per day is more than double that faced by non-smokers.

The research, part of the Sax Institute's 45 and Up study, draws on the health records of more than 200,000 patients tracked over a period of four years, and found that smoking is even more toxic than previously thought.

It found that two-thirds of smoker deaths could be directly attributed to tobacco use, much higher than international estimates that smoking directly contributes to half of all smoker deaths.

Lead researcher Professor Emily Banks from the Australian National University said that although it was well established that smoking was bad for health, the research demonstrated just how bad it was.

"The risks associated with smoking 10 cigarettes a day are similar to the risks of death associated with being morbidly obese, so with having a body mass index of 35 or more," Professor Banks said.

"Most light smokers wouldn't think of themselves as having a risk that is similar to someone who is morbidly obese.

"People don't realise how damaging even light smoking is for your health – for cancer, heart disease, lung disease and a range of other conditions."

Researchers also found that current smokers were three times more likely to die than people who had never smoked, and the risk of dying increased with the number of cigarettes.

Within the four-year period covered by the study, the life expectancy of smokers was 10 years less than that of non-smokers.

"What we see is a continuum of increasing risk against increasing numbers of cigarettes being smoked. There's no threshold, there's no point where you can say that's a safe number of cigarettes," the study said.

Tobacco smoking is estimated to be responsible for 9.7 per cent of the total disease burden in Australia.

Kirsty Waterford

TO COMMENT CLICK HERE

Malaria vaccine could be ready by 2015

The world's first malaria vaccine could be available within the next 18 months, marking a major advance in efforts to eradicate a disease that kills more than half a million people, many of them children, every year.

British pharmaceutical company GlaxoSmithKline (GSK) is preparing to submit a malaria vaccine for regulatory approval following a large-scale clinical trial which showed it resulted in a sharp reduction in disease risk among young children.

The vaccine, RTS,S, has been developed by GSK in partnership with the Path Malaria Vaccine Initiative and with support from the Bill & Melinda Gates Foundation, and was tested in a clinical trial involving 15,500 children in seven African countries – the largest such test ever held on the continent.

The trial found that, in the 18 months following vaccination, children aged between five and 17 months who had received RTS,S were 46 per cent less likely to contract malaria than those who had not been vaccinated.

The vaccine was also shown to have some efficacy for the very young, with the risk of clinical malaria 27 per cent less in infants aged between six and 12 weeks who had been given RTS,S compared with those who had not.

The trial results were presented to a medical meeting in Durban, South Africa, and in a statement GSK outlined the steps it plans to take to get the vaccine on the market.

"Based on these data, GSK now intends to submit, in 2014, a regulatory application to the European Medicines Agency (EMA)," the company said, adding that it hoped the World Health Organisation would recommend the use of RTS,S from as early as 2015 if it wins the approval of the EMA.

According to the WHO, there were about 219 million cases of malaria in 2010, including around 660,000 deaths.

The Organisation noted that progress was being made in controlling the disease, with mortality rates down by 25 per cent since 2000.

A lead investigator with the RTS,S trial, Halidou Tinto, told the BBC that "progress is being made with bed nets and other measures, but we need more tools to battle this terrible disease".

In South Africa, there has been a massive 85 per cent drop in malaria mortality in the past 12 years following the widespread application of the controversial pesticide DDT.

The chemical is linked to birth defects, infertility and cancer, and has been banned in many countries.

But advocates for its use point out that the number of malaria infections in South Africa soared between 1996 and 2000 when DDT use was halted, and have steadily declined since it was reintroduced.

Adrian Rollins

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Sex-based abortions legal in UK

Britain's top prosecutor has admitted that sex-selection abortions are not illegal under current laws.

In an assessment that has been met with anger in sections of the community, UK Director of Public Prosecutions Keir Starmer said that, contrary to conventional understanding, aborting a foetus because of its gender was not technically illegal in Britain.

Mr Starmer revealed his conclusion when explaining why the Crown Prosecution Service was not proceeding with a case against two doctors accused of offering to abort babies because of their gender.

The two doctors were originally considered for prosecution after being secretly filmed offering to abort baby girls.

But Mr Starmer said it appeared that they had not technically breached the law.

"The law does not, in terms, expressly prohibit gender-specific abortions," he was quoted in the West Australian as saying. "Rather, it prohibits any abortion carried out without two medical practitioners having formed a view, in good faith, that the health risks of continuing with a pregnancy outweigh those of termination."

In coming to his view, Mr Starmer also drew on guidelines issued by the British Medical Association, which he said allowed that "there may be circumstances in which termination of pregnancy on grounds of foetal sex may be lawful".

In its guidelines, the BMA said it was "normally unethical" to abort a foetus because of its gender, but added that the views of the mother should be considered, and "in some circumstances doctors may come to the conclusion that the effects are so severe as to provide legal and ethical justification for a termination".

Adrian Rollins

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Open all hours: UK Govt plan for GP services

The British Government has announced plans to extended GP surgery opening times, including operating on weekends, in order to help take pressure off hard pressed public hospitals.

Under the plan, unveiled by Health Secretary Jeremy Hunt, general practices will be open 12 hours a day, seven days a week, to make it easier for working patients to see their family doctor, rather than going to hospital accident and emergency departments for treatment.

UK Prime Minister David Cameron said a £50 million pilot scheme to test the proposal would be rolled out across the country, and invited practices to take part.

"I think it is the right approach to look at this because, obviously, our accident and emergency departments do a brilliant job, but they do have four million more people going through them than was the case in 2004," Mr Cameron said on ITV's Daybreak program.

The British Prime Minister said increasing practice opening hours would make it easier for those with a job to get to see a doctor, rather than inundating public hospitals.

"Millions of people find it hard to get an appointment to see their GP at a time that fits in with their work and family life," Mr Cameron said.

"Sometimes people using accident and emergency really just need to see a GP, but for hard-working people it is often too difficult because you are at work, you can't get an appointment at the time that fits."

National Health Service medical director Sir Bruce Keogh said he had been contemplating the move to seven-day GP services "for several years now", as a way to improve the provision of health care.

"Things have to change radically," Sir Bruce told the *Sunday Express*. "Patients should never have to accept that the risk of disease, and treatment is made worse because of the way we deliver services."

"The rest of society has moved forward at weekends. Why not health care?

"This is not just about emergency care. It is also about access to doctors, diagnostics and elective operations so that people do not have to miss work to get health care.

"If someone needs a day-case operation, why can't they have that on Saturday, recover on Sunday and be back to work on Monday?"

But the plan has drawn the ire of GPs, not least because the Government has so yet to identify any increase in funding – beyond that for the pilot scheme – to support longer GP surgery opening hours.

Royal College of General Practice Chair Dr Clare Gerada denounced politicians for using GPs as a "soft target".

According to a report in *The Guardian*, Dr Gerada told 1500 family doctors attending the College's annual conference earlier this month that "it can sometimes feel as if we're in the midst of an orchestrated campaign against us. We're constantly under fire because we're a soft target for politicians and the media.

"They hold us unfairly responsible for anything that goes wrong in the NHS – for the failures in emergency departments and social care, for the problems with bed-blocking. Berating us for not working out of hours … You name it, our hard-working profession is under fire almost daily," Dr Gerada said.

Adrian Rollins

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INFORMATION FOR MEMBERS

Changes to veteran health care payment arrangements

Health care subsidy arrangements for defence force veterans injured or who suffered diseases in the course of their service before mid-2004 are being changed.

The Department of Veterans Affairs (DVA) has announced that veterans currently eligible for benefits under the terms of the Safety, Rehabilitation and Compensation Act 1988 (SRCA) will, from early December, no longer have to seek reimbursement from the Department for care costs.

From 10 December, SRCA clients will be subject to normal DVA treatment card arrangements, including the use of the DVA benefits schedule.

The DVA's Principal Medical Adviser Dr Graeme Killer admitted that the change would in some cases result in lower payments to providers.

But Dr Killer said both providers and their patients would benefit from a smoother, faster, and more convenient and consistent payments process.

"Currently, payment for the treatment of SRCA clients is processed through reimbursement arrangements, with an administrative burden for both clients and providers," he said. "This involves seeking prior approval from the DVA for most services, before sending invoices in to either be paid to the treating provider, or as a reimbursement to clients for payments they have made."

Dr Killer said bringing the assessment and processing of payments for SRCA patients in line with those of the broader veteran community would benefit all.

"It is understood that in some situations the use of the DVA schedule will result in a lesser payment to providers," he said. "However, using the card will benefit providers, as there will be greater consistency across procedures when dealing with [the] DVA, faster turnaround in payment for services, and reduction in administrative burden on practices."

In Europe, the air is not so sweet...

Most Europeans are breathing air so polluted that it is causing cardiovascular disease and resulting in premature deaths.

A report by the European Environment Agency has found that although progress has been made in the past decade in cutting down on some pollutants, Europeans are still being exposed to dangerous levels of particulate matter and ground-level ozone.

The study, based on ambient air measurements collected across 38 European countries between 2002 and 2011, found that 96 per cent of city dwellers were exposed to very fine particulate matter at concentrations that far exceed World Health Organisation recommendations, and 98 per cent are breathing air containing concentrations of ozone also in excess of WHO guidelines.

The results have been welcomed as a wake-up call for policymakers to redouble efforts to improve air quality, particularly in light of improved understanding of the serious damage to health caused by fine and very fine particulate matter.

According to the report, *Air quality in Europe – 2013,* progress has been made in reducing concentrations of dangerous pollutants such as carbon monoxide and lead, which are now judged to be at acceptable levels.

But it found there had been a marked increase in the presence of particulate matter (PM), ozone and reactive nitrogen substances, which posed "a significant threat: particulate matter and ozone pollution are particularly associated with serious health risks".

Particulate matter emissions from fuel combustion in the commercial, institutional and household sector has increased by 7 per cent since 2002.

"In terms of potential harm to human health, PM poses the greatest risk, as it penetrates into sensitive regions of the respiratory system and can lead to health problems and premature mortality," the report said.

"The health effects of PM are caused after their inhalation and penetration into the lungs and blood stream, leading to adverse effects in the respiratory, cardiovascular, immune and neural systems.

"A fraction of ultrafine particles may even enter the brain directly through the nose."

The AMA has for some time been warning of the health risks posed by air pollution, particularly particulate matter, and welcomed a Senate committee report released in August which called for stricter air quality standards, and improved monitoring and data collection arrangements.

AMA President Dr Steve Hambleton said at the time of the release of the Senate report that current air quality standards had failed to keep pace with scientific evidence, and many hazardous pollutants were not subject to routine or independent monitoring.

"The enforcement of existing standards is poor and fragmented," Dr Hambleton said. "We need stronger regulation and monitoring of emerging industries, such as coal seam gas extraction and other non-conventional mining operations that affect the environment."

The AMA President said health assessments should be conducted before new mining operations commence, and strict air quality standards should also be applied to current conventional practices, including the transport of coal in uncovered wagons.

"To this effect, we welcome the report's recommendation for health impact assessments for new developments, and other recommendations for air quality monitoring, research and data collection," he said.

The European report found that households had become a major source of PM pollution.

"Combustion of biomass by households – burning fuels such as wood and coal – is an important source of directly emitted PM," it said. "In fact, biomass combustion has become a more important source of air pollution. This is because wood burning is often relatively cheap, and is considered as an environmentally friendly source of energy, since it is renewable and carbon-neutral."

Adrian Rollins

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Vibrant life in heart of prairie country

BY **ADRIAN ROLLINS, EDITOR, *AUSTRALIAN MEDICINE***

'City museum' – it is a pairing of words almost designed to kill off traveller interest.

As a tourist attraction, it seems destined to be frequented only by civil engineers, architects and the occasional lost Scandinavian.

But in the quirky mid-west US city of St Louis, the city museum is nothing like you would expect.

Envisage giving filmmaker David Lynch and a group of eight-year-olds their head in dreaming up the weirdest and most interesting indoor playground they could image, and you might get something close to the St Louis City Museum.

Housed in a massive abandoned shoe factory and warehouse close to the heart of the CBD, it is the creation of local sculptor Bob Cassilly and a team of 20 artisans who – over many years – created a child's fantasyland of tunnels, slides, fish tanks, cubby holes, playgrounds, circuses and trains.

Made from recycled and reclaimed building materials, abandoned machinery and sculpted concrete, tiles and glass, it extends through all seven floors and spills over the exterior, encasing the building in a steel web that has also entrapped a couple of decommissioned jet fighters.

From the ground floor adventure playground - where Gaudi-esque walls and ceilings are honeycombed with child-sized tunnels, caves and hideouts – to the rooftop garden complete with Ferris wheel and school bus, it is a full-scale amusement park, but one without the tacky sideshow food or the commercialised hype of Disneyland.

A creation of the inspired and unexpected, it seems oddly appropriate for the city that surrounds it.

St Louis rarely rates much of a mention as a tourist destination, and we barely gave it a thought while planning our trip along Route 66, which begins in Chicago and ends in Los Angeles.

From outward appearances, the city – home to almost three million people - does not appear particularly welcoming.

Big industrial buildings and plants, many of them fallen into disuse, line both sides of the Mississippi River, lending it a gritty and workmanlike character.

Its principal landmark is the Gateway Arch – a giant stainless steel structure soaring almost 200 metres above the ground at its apogee - erected as a memorial to the millions of adventurers and settlers who passed through St Louis on their way to occupy America's west.

The sleek, shiny archway, visible from much of downtown, sits in stark contrast to the massive edifices of brick and marble that line much of the city's streets and reflect its former glory days as one of the most important transport and trading hubs in the country.

The city's fortunes sagged during the latter part of last century but, out of the scruff, a vibrant centre of art, music and culture has emerged.

Once a dangerous destination off-limits to all but daredevil travellers, downtown St Louis has been reborn.

Massive old warehouses have been reclaimed and converted into swank apartments, while once-abandoned shopfronts are now lined with sheik boutiques, galleries, bars and restaurants.

The streets surrounding the City Museum and the Stevens Institute of Business and Art fairly thrum with energy as diners and revellers spill out of pubs and eateries, and corner bars resound to live music and theatre.

Nearby, crowds throng to Busch Stadium, home to the famous St Louis Cardinals, and which seems like the MCG of baseball.

After a couple of days travelling through the quiet back roads of Illinois' prairie lands, St Louis is an unexpected and intriguing stopover.

It might never budge New York, Washington DC or New Orleans from the top of most tourist itineraries, but those with a taste for the different will find much to like in the city on the river.

Where	St Louis, the capital of Missouri, sits on the Mississippi River, around 475 kilometres south-west of Chicago.
How to get there:	
Flying	return flights from Los Angeles start from around $490. Flying time is approximately three hours.
Train	trains depart Chicago for St Louis several times daily. Travel time is 5.5 hours, fares from $74.

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Mazda6 Touring Diesel - wisdom, intelligence and harmony

BY **DR CLIVE FRASER**

Mazda has been making motor vehicles in Japan since 1931.

Its predecessor, the Toyo Kogyo Company, had made machine tools from 1920 until 1931 when its first vehicle, the Mazdago, ran off the production line.

It was a three-wheeled autorickshaw with handle-bars and a one cylinder air-cooled engine.

During the Second World War, Toyo Kogyo made armaments, most notably the Type 99 Arisaka infantry rifle.

By the 1960s, Mazda was investing heavily in the development of Wankel rotary engines, and is now the sole world manufacturer.

The first Mazda sedan that took my eye was the Bertone-styled Mazda 1500 in 1966.

My father had considered buying the 1500, but bought a locally-made HR Holden instead.

It had only been a generation since the Second World War. Japanese cars were yet to be trusted and there were un-founded doubts about reliability.

A friend bought a Mazda Capella in the 1970s and, in 1980, I almost bought a Mazda 626, but opted for a Chrysler Sigma with a larger engine and less longevity.

Many 626s followed in the 1980s, and in 1983 the Mazda 626 was the Wheels magazine Car Of The Year.

Ford even manufactured a variant of the 626 in Australia, the Telstar.

My partner owned a Telstar TX5 Ghia with an electronic dashboard, but it still wasn't exactly a Mazda.

In 2003, Mazda changed their numbering system and released the Mazda6, which is the subject of this month's road test.

Having never actually owned a Mazda myself, I desperately wanted to like this car, as I had pencilled it onto my shopping list.

I liked the way it looked, from the front.

I liked the quality of the finish and the goodies inside.

Everything was going great until I turned the key (sorry, keyless start), if you know what I mean.

I just didn't like the way it sounded.

Having been spoilt by the quietness of Mercedes, BMW and VW diesels, in ascending order, I was a little surprised by how noisy the motor was, or at least how noisy it seemed compared to the formidably quieter competition.

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Mazda6 Touring Diesel - wisdom, intelligence and harmony

BY **DR CLIVE FRASER**

...CONTINUED FROM PAGE 35

There is no shortage of go from the diesel Mazda6, with 129kW of power and 420Nm of torque.

It takes off well from a standing start and, like all diesels, it doesn't lose momentum on hill climbs.

Back in the traffic, the i-Stop feature shuts the engine down when stopped.

While i-Stop saves fuel, it is a little disconcerting at first.

With no motor running it's more like being parked at the traffic lights, but as soon as you take your foot off the brake pedal the motor fires up and away you go.

Going diesel in a Mazda6 comes at a $3000 price premium over the SkyActiv petrol version.

Power only drops by 7 per cent by going from petrol-powered to diesel-powered, but torque is up by a whopping 68 per cent, making the diesel feel like it has two more cylinders.

Fuel consumption overall is 18 per cent better in the oil-burner.

Even the Mazda6 base model is comprehensively equipped with keyless starting, dual-zone climate control, paddle shifter gear change, emergency brake assist, rain-sensing wipers and satellite navigation.

Going up-market to the top shelf Atenza adds leather seats, 19-inch wheels, radar cruise control, blind spot monitoring, lane departure warning, a sun-roof and Bi-Xenon headlights that turn around corners.

A wagon is $1300 more than a sedan.

Overall, I can see why the Mazda 6 is a favourite among conservative bowls club members. It's a quality product at an affordable price.

If my hearing keeps on deteriorating I soon won't notice the clatter from the motor, and some diesel aficionados even like that sound.

Would I buy a Mazda6?

Well, maybe.

It's still on my list.

Automotive lead-acid batteries	
For	Build quality, reliability and retained value.
Against	Sounds like a diesel.
This car would suit	Volvo drivers and older doctors, like myself.
Specifications	2.2 litre 16 valve 4 cylinder diesel 129 kW power @ 4,500 rpm 420 Nm torque @ 2,000 rpm 6 speed automatic transmission 5.4 l/100 km (combined) $55,000 on the road Qld, Vic and NT $55,500 on the road where IQ's are higher
Fast facts	Only 4 per cent of passenger vehicles sold in Australia are diesel-powered. The Mazda6 diesel is not currently sold in the USA. The name "Mazda" is taken from the Zoroastrian god of wisdom, intelligence and harmony.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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