AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Medical training: time for action

COAG must act now to head off intern, RMO crisis, p4

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CPD TRACKER

AMA

ISSUE 25.22 - NOVEMBER 4 2013

AUSTRALIAN
Medicine

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

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Good Advice – Taken as Directed

BY AMA PRESIDENT DR STEVE HAMBLETON

The first clear evidence of how the incoming Health Minister, Peter Dutton, was going to settle into the role was seen last week with the announcement that 50 new and amended medicines have been added to the Pharmaceutical Benefits Scheme (PBS).

During the election campaign, the Coalition resolved to lift the Cabinet approval ceiling for the PBS to $20 million, restore efficiency to the listing process, and bring drugs to market more efficiently. All of these were supported by the AMA.

Among the approvals was Dabrafenib, which targets a genetic mutation present in about half of melanoma cases; Sunitinib, which targets pancreatic cancer; and Denosumab was extended to men suffering osteoporosis. In total, around 230,000 people stand to benefit from these listings.

In relation to medicines for the Australian market, the AMA has been a long term supporter of the Therapeutic Goods Administration (TGA), which assesses therapeutic products for efficacy and safety before they are allowed to be registered and sold.

The AMA also believes there is merit in the addition of some "public" funding to the TGA so it can increase the activities that it carries out in the public interest. Our Therapeutics Committee is currently looking into this.

We also support the Pharmaceutical Benefits Advisory Committee (PBAC), which considers both the effectiveness and cost of the proposed drugs. I was a PBAC member in 2008 and 2009.

After extensive analysis, PBAC makes a recommendation to the Minister for Health about which drugs and medicinal preparations should be subsidised by the Australian Government under the PBS.

On many occasions in the past, we have seen delays in drugs getting subsidised by the PBS despite a positive recommendation from the PBAC. This was effectively shifting the decision about which drug to list from a group of highly trained medical and pharmaceutical professionals, supported by economists, to a group of Cabinet politicians who we would not expect to have the required professional expertise, but who should at least have the very best expert advice.

The most obvious example of a delayed listing was Pradaxa which, after an extended period of time, was finally listed for our patients with non-valvular atrial fibrillation.

The cost- effectiveness analysis carried out by PBAC, to which all drugs are subjected, helps to maximise the benefits of the particular drug when it is prescribed within the recommendations.

We currently spend over $8 billion a year on pharmaceuticals and, up until recently, the price was rising very fast.

The rigorous listing process ensures that when drugs become available we are paying the right price. But the PBS re-pricing process has meant long delays in realising the savings to the PBS when generics are introduced into the market at the end of patent protection of the parent drug.

As we know, this has resulted in Australia paying much more for some drugs than many countries around the world and, indeed, multiples of what is paid for drugs like statins in New Zealand.

What we need is a more efficient feedback loop to allow the price falls that are occurring due to increased competition to be passed on to the Australian community.

In fact, in these current economic times, it is really the cost savings from the introduction of generic statins and other drugs that have provided the fiscal headroom to be able to afford the listing and subsidisation of the drugs mentioned above.

We need to continue to improve the cost-saving efficiency if we are to be able to list new drugs for the use of the Australian population in a timely way.

> "It should be abolished immediately. This would free up the equivalent of up to 25,000 patient consultations while doctors wait for their calls to be answered"

In relation to pharmaceutical benefits and red tape, one of the biggest time wasters in medical practice is the long wait for phone authority prescriptions. It has been estimated that up to six million phone calls are made every year to the PBS authority line.

Waiting on the phone for someone to answer wastes an enormous amount of time. We don't know of any evidence that suggests abolishing the authority approvals process would cause a blowout in costs.

It should be abolished immediately. This would free up the equivalent of up to 25,000 patient consultations while doctors wait for their calls to be answered.

AMA Secretary General Anne Trimmer and I have already raised this issue with the Health Minister, who is intending to take a close look at this it. No more hanging on the telephone? Let's hope.

TO COMMENT CLICK HERE

Act now to prevent training crisis, govts told

The AMA has called on the nation's Health Ministers to act immediately to head off a looming critical shortage of medical training places that threatens to derail the careers of hundreds of aspiring doctors and undermine efforts to improve access to health care.

AMA President Dr Steven Hambleton and Chair of the AMA Council of Doctors in Training Dr Will Milford have written to the nation's Federal, State and Territory Health Ministers urging them to begin work on a national medical training plan when they meet later this month.

Dr Hambleton and Dr Milford said that the plight of around 20 Tasmanian interns and resident medical officers (RMOs), who have failed to secure training places next year to continue their studies, highlighted increasingly severe shortcomings in the medical training pipeline that threaten to derail efforts to boost doctor numbers and prematurely snuff out the careers of dozens, if not hundreds, of medical graduates.

The senior AMA officials warned of a "growing bulge" of RMOs seeking registrar positions, and said the potential for locally-trained doctors to miss out on a training position was "extremely troubling".

In their letter, Dr Hambleton and Dr Milford said that although each Government was working to provide more prevocational and specialist training places, "this is being done in a very unplanned and uncoordinated way that is not necessarily matched to community need".

The AMA Council of Doctors in Training, which met late last month, said the forthcoming Standing Council on Health meeting was a critical opportunity to immediately begin work on a national medical training plan.

Speaking following the Council meeting, AMA Vice President Professor Geoffrey Dobb said the crisis in medical training was not only a tragedy for those graduates denied the opportunity to complete their

studies, but was a serious problem for the country as it tried to address shortages and gaps in the medical workforce, now and in the future.

"The Health Workforce Australia *Health Workforce 2025* report last year warned that Australia needed to increase prevocational and specialist training places for doctors if the medical workforce is to meet future community need," Professor Dobb said.

In its report, HWA warned the nation was facing a shortage of 2700 doctors by 2025 unless there was nationally coordinated reform of the medical training system.

The pressure on prevocational and specialty training places has intensified sharply in the past nine years as the number of medical graduates has soared, from just 1287 in 2004 to more 3100 last year, and is expected to reach 3970 in 2016.

Federal, State and Territory governments reached a temporary, last-minute deal late last year to avert a critical shortage in training places for 2013 that potentially would have left more than 100 medical graduates stranded, and Dr Milford has urged against a repeat of such ad hoc solutions.

Both he and Dr Hambleton have written to the Australian Health Ministers' Advisory Committee seeking details on the number of RMO and registrar positions that each State and Territory will offer next year.

The AMA officials also questioned the continued influx of junior doctors from overseas, with currently around 1550 RMOs employed on 457 visas.

"Given the growing number of Australian-trained doctors seeking RMO and registrar positions, it is very difficult to understand why so many temporary resident doctors are still being used to fill local vacancies," they wrote.

The AMA has backed proposals from HWA for the establishment of a National Medical Training Advisory Network to improve the coordination of the medical training pipeline, and wants this month's meeting of Health Ministers to agree to commence work on a five-year national medical training program.

"We understand these proposals will be on the agenda at the Health Ministers' meeting, and the AMA and the AMACDT urge all governments to adopt both proposals and start work on them straight away," Professor Dobb said, adding that a national training plan was first promised by the end of 2011, "and we are still waiting".

"The Australian community cannot afford any more delays with this important work," he said.

Adrian Rollins

TO COMMENT CLICK HERE

Flawed Qld contracts could spark rush for hospital exits

There could be a mass exodus of doctors from the Queensland public hospital system unless draconian changes to employment conditions are quickly reversed, the AMA has warned.

The warning followed a decision by the Queensland Government to scrap its existing enterprise agreement with public hospital Senior Medical Officers and instead place them on individual employment contracts.

In a meeting convened soon after the Government's announcement, the AMA Council of Salaried Doctors said the contracts being offered were unbalanced and unfair, and could force doctors into private practice or convince them to leave the State altogether.

The meeting, which included senior public hospital doctors from around the country, unanimously condemned the proposed changes – due to come into effect from 1 July next year – as a retrograde step that would harm public hospital doctors and their patients.

AMA President Dr Steve Hambleton said the proposed contracts would strip away key provisions in existing employment agreements regarding the management of doctor fatigue, including mandated rest breaks and limits on hours, as well as robbing doctors of important workplace rights such as access to dispute resolution and unfair dismissal procedures.

Dr Hambleton warned that the change could lead to an exodus of senior doctors from Queensland public hospitals.

"The proposed new individual contracts will strip away key employment rights and undermine the progress Queensland has made in growing its public sector medical workforce," the AMA President said.

"These draconian contracts will remove key protections such as fatigue provisions and rest breaks, limits on hours, access to unfair dismissal, dispute resolution and grievance procedures.

"The changes are at odds with the rest of the country, and raise genuine serious concerns that many Senior Medical Officers in Queensland will move interstate or abandon the public hospital system to work in private practice."

But Queensland Health Minister Lawrence Springborg has so far defied calls to reverse the decision, declaring the change in employment terms had been forced on the Government by a spiralling overtime bill for public hospital specialists.

Mr Springborg told ABC Radio that "there was an extraordinary amount of overtime being done that we didn't have the accountabilities around it that were necessary".

"We did need to do something to control that, and that's what we will be doing," the Minister said.

A spokesman for Mr Springborg told *The Australian* the individual contracts would abide by the published policies of Queensland Health and Hospital and Health Services, including those regarding fatigue management.

The spokesman said the contract would ensure doctors got paid for the work they performed, and would include annualised payments for on-call and overtime.

But Dr Hambleton said the Government needed to reconsider the change.

He said successive enterprise agreements had helped to deliver a substantial boost in the number of Senior Medical Officers working in Queensland, and warned the proposed individual contracts would undo much of this progress.

"If the Newman Government proceeds with these ideologically-driven changes, Queenslanders will soon find it much harder to access care in their local public hospital, and they will experience longer waiting times," the AMA President said.

Adrian Rollins

TO COMMENT CLICK HERE

Sport told its time for last drinks

The AMA is at the forefront of efforts to get the sports industry to kick its alcohol habit, calling for an inquiry into alcohol advertising and promotion and backing far-reaching changes to the taxation of wine.

AMA President Dr Steve Hambleton said there was an urgent need to reconsider the way alcohol was marketed and promoted in Australia, particularly through sport.

"Young Australians are exposed to an unprecedented level of advertising that glorifies alcohol," Dr Hambleton said.

He was commenting on the release of research commissioned by The Salvation Army that showed significant community concern about the strong links between alcohol and sport.

Seventy-two per cent of adults surveyed by Roy Morgan Research said they thought alcohol and sport had become too closely related, 70 per cent thought it was encouraging young people to drink, and 67 per cent thought it was time to start phasing alcohol sponsorship of sport out.

"Australia is a sporting nation, and the alcohol industry concentrates a lot of its promotional and sponsorship activity on live broadcasts of the most prominent and popular sporting events, including grand finals that are watched by millions of people," Dr Hambleton said, with products promoted during ad breaks, on sporting grounds, on billboards and on players' jerseys.

The AMA President said there was "strong evidence" that the more young people were exposed to alcohol advertising, the earlier and more heavily they drank.

"Associating alcohol with sport sends a clear message to young people that drinking and sport go together."

But sports organisations so far appear unrepentant about their strong links with the alcohol industry and its sponsorship money.

Last month Cricket Australia refused to run an advertisement declaring "Alcohol and sports don't mix" during the Ryobi Cup in Sydney, while Cricket NSW has just signed a three-year sponsorship deal with Carlton & United Breweries, which has also secured naming rights for the upcoming one-day international series between Australia and England.

A Cricket Australia spokesman told *The Sydney Morning Herald* that it was justified in rejecting an ad with a message that it saw as at odds with its own position on alcohol consumption and sport.

"It is better to engage with the reality that many fans enjoy a responsible drink than it is to turn them off with a prohibition message they don't believe," the spokesman said.

Meanwhile, the Federal Government said it had no current plans to alter the taxation regime for alcohol.

It was responding to a call from the National Alliance for Action on Alcohol, of which the AMA is a member, to replace the current wine equalisation tax with a tax on alcohol by volume, which it has been estimated would collect an extra $1.32 billion in tax revenue from the wine industry.

While the alcohol industry is so far successfully resisting efforts to change its taxation or curb its sports sponsorship, it faces the likelihood that in future it will have to include the energy content of its product on its labels.

Food Standards Australia and New Zealand has commissioned a cost-benefit analysis of a proposal that the kilojoule content of packaged wine, beer and spirits be inscribed on the packaging.

Adrian Rollins

TO COMMENT CLICK HERE

AMA IN THE NEWS

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

Print/Online

Gap growing for patients as GPs lift fees, *Adelaide Advertiser,* 16 October 2013

The value of Medicare rebates will plummet, covering less than half the cost of seeing a doctor from next month. The AMA has recommended that doctors raise fees from $71 to $73 from November 1.

Seniors may skip doctors, *Canberra Times*, 17 October 2013

The AMA has advised its members to increase standard GP consultation rates by $2, claiming the rebate has failed to keep up with increasing practice costs.

Why those who care also need caring, *Adelaide Advertiser*, 18 October 2013

The AMA used Carer's Week to call for greater support for respite programs for carers.

GPs claim bulk billing rates will fall, *Australian Financial Review*, 19 October 2013

Doctors claim bulk billing rates at general practices will fall from record highs, and some practices will have to close, if the Government does not reverse a freeze on Medicare rebates. AMA President Dr Steve Hambleton said the freeze on rebates was putting pressure on already thin operating margins for GPs.

Their shout: cricketers toast brewery's deal, *Sydney Morning Herald*, 19 October 2013

Alcohol remains a fraught issue for those who run cricket. AMA President Dr Steve Hambleton said young people are exposed to unprecedented levels of alcohol advertising.

The obesity 'sickness', *Hobart Mercury*, 19 October 2013

Obese Australians should be treated as if they have a disease and have their treatment subsidised by Medicare, said the AMA.

Ban booze adverts in sport, *Adelaide Advertiser*, 21 October 2013

The Federal Government has been urged to review alcohol advertising at sporting events amid concerns children are being encouraged to drink. The AMA has previously encouraged sporting codes to dump their reliance on alcohol companies for sponsorship.

Big data will reduce errors in patient care, *Australian Financial Review*, 22 October 2013

With 9.3 per cent of Australia's gross domestic product spent on health care, there is significant scope for improvement in productivity to drive better health outcomes, a conference on the future of health care was told. AMA President Dr Steve Hambleton said the key to extracting better productivity within the health care sector was through digitisation.

To chart the nation's health, *Australian Financial Review*, 22 October 2013

Better use of data could be used to support preventive health efforts – a proposal that is only given tacit attention in health policy debates. AMA President Dr Steve Hambleton said Australia's health system was exceptionally good at acute care, but there was a need to make sure there was sufficient investment at "the front end" of health care.

Medibank sale has advisers circling, *The Australian*, 24 October 2013

Investment banks are salivating over the government's move to assess a $4 billion float of Medibank Private. The privatisation plan drew opposition from the AMA and the federal Opposition amid claims it would put upward pressure on health insurance premiums.

NDIS will be a struggle for Medibank: AMA, *Australian Financial Review*, 26 October 2013

The AMA is concerned Medibank Private would struggle to manage the administrative responsibilities of the National Disability Insurance Scheme based on its substandard record in coordinating health care services for the Australian Defence Force.

Radio

Dr Steve Hambleton, ABC Southern Queensland, 21 October 2013

AMA President Dr Steve Hambleton discussed the electronic health record system. He said that one million people have signed up for the electronic records, but that only 5000 have clinically important information listed.

Dr Steve Hambleton, 2GB Sydney, 21 October 2013

AMA President Dr Steve Hambleton discussed alcohol advertising and promotion. He said a Salvation Army survey had shown that there is a significant community concern about the links between alcohol and sport.

Dr Steve Hambleton, 2UE Sydney, 22 October 2013

AMA President Dr Steve Hambleton discussed the dangers of inhaling bushfire smoke and advised people to avoid it. He said people who already had chronic lung conditions were at risk.

...CONTINUED ON PAGE 8

AMA IN THE NEWS

...CONTINUED FROM PAGE 7

Dr Steve Hambleton, 891 ABC Adelaide, 22 October 2013

AMA President Dr Steve Hambleton discussed joint replacements. He said in Australia there are more than 80,000 joint replacements annually.

Dr Steve Hambleton, 666 ABC Canberra, 23 October 2013

Senior medical officers in the Queensland public hospital system are protesting against what they say is the return of Work Choices. AMA President Dr Steve Hambleton said there was a serious concern doctors will leave the Queensland public health sector as a result of the new contracts.

Dr Steve Hambleton, 2CC Canberra, 24 October 2013

AMA President Dr Steve Hambleton discussed the sale of Medibank Private. He said if Medibank Private was bought by another health insurer then competition would decrease.

Dr Steve Hambleton, 4BC Brisbane, 26 October 2013

AMA President Dr Steve Hambleton discussed a plan by private health insurer NIB to market packages for off-shore surgical procedures. He said that people have been going offshore for cheaper surgery for some time, but the AMA was concerned about the trend because of frequent complications and poor patient outcomes.

Dr Steve Hambleton, 666 ABC Canberra, 28 October 2013

AMA President Dr Steve Hambleton expressed concern about a proposed policy by a private health insurer to introduce insurance packages to cover medical tourism. He said medical training in Australia was world class, and the country did not have the multi-resistant bugs that existed in other parts of the world.

TV

Dr Steve Hambleton, Channel 7 Brisbane, 17 October 2013

AMA President Dr Steve Hambleton expressed concerns about chiropractors practicing on infants and young children. He said there was no credible scientific evidence that chiropractic treatment of infants and children was of benefit.

Dr Steve Hambleton, ABC News 24, 23 October 2013

AMA President Dr Steve Hambleton discussed health concerns for those dealing with the NSW bushfires. He said there has been a large increase in hospital emergency department presentations associated with inhaling smoke, particularly among those with conditions such as asthma.

Dr Steve Hambleton, ABC1 Canberra, 29 October 2013

The ABC resisted pressure to withdraw a program that was part of a series calling into question the scientific evidence linking cholesterol to heart disease. AMA President Dr Steve Hambleton said the AMA welcomed the debate.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

AMA in action

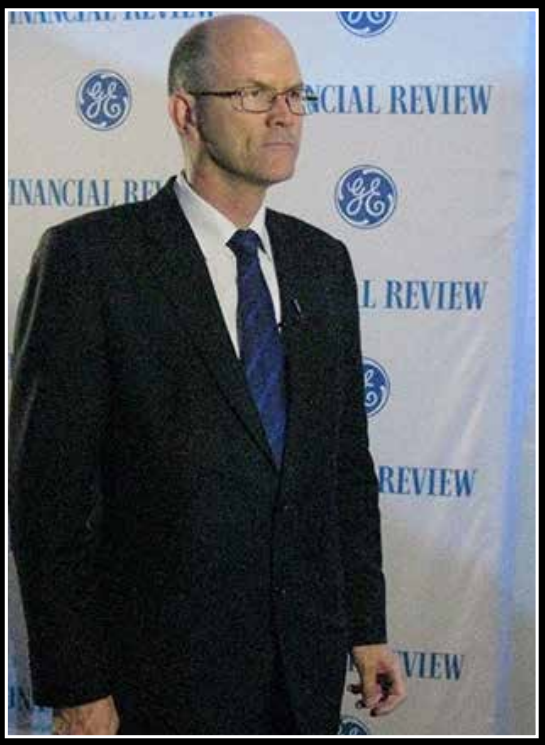
Dr Hambleton started his fortnight in Canberra meeting with the AMA Executive Council, which discussed developments in national health policy along with internal AMA matters. Dr Hambleton was also busy in the media, including providing advice about the danger posed by inhaling bushfire smoke and the risks involved in medical tourism, before finishing the week by attending an AMA Council of General Practice Committee meeting.

Dr Hambleton met with AMA Queensland President Dr Christian Rowan to tour Greenslopes - Australia's largest private hospital – with CEO Mark Page, Dr Jim Houston Director of Medical Services and, Carmel Monaghan, Marketing & Public Affairs Manager. The Government funded 100 internship placements at the hospital and Dr Hambleton was shown how the hospital was integrating students into their every day practices.

Earlier in the month, Dr Hambleton was a participant in the Australia 2.0 forum, an initiative of *The Australian Financial Review* which brought together policymakers and industry and business leaders to discuss issues regarding the future of health care, energy, productivity and infrastructure. He also attended GP13, the annual conference of the Royal Australian College of General Practitioners', which was held at the Darwin Convention Centre.

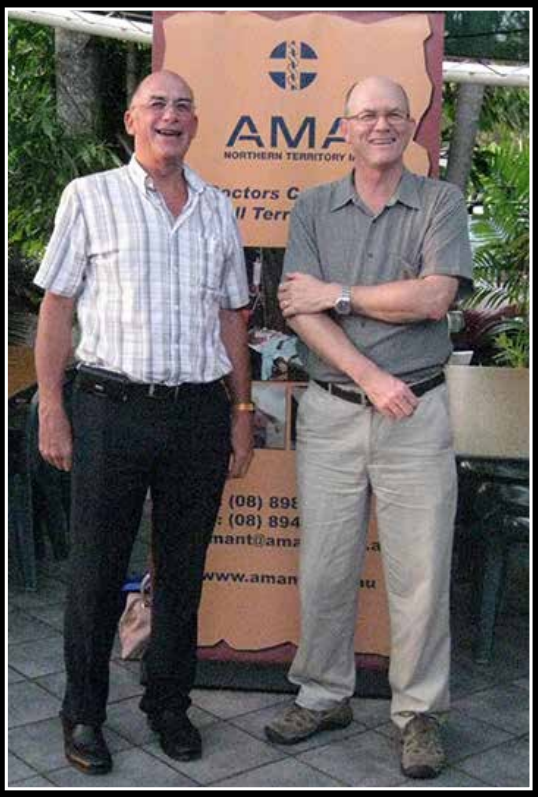
Former AMA President Dr Andrew Pesce attended the World Medical Association Conference in Brazil last month, which was chaired by former AMA President Dr Mukesh Haikerwal.

TO COMMENT CLICK HERE



AMA President Dr Steve Hambleton at the Australia 2.0 initiative

Dr Hambleton with Dr David Cooper (right) CEO of AMSANT, John Patterson and Chair of AMSANT Shawn Hefferen



Dr Hambleton with AMA NT President Dr Peter Beaumont

AMA Council of General Practice meeting in AMA House, Canberra

AMA Executive Council meeting at AMA House Canberra, (l to r) Dr Brian Owler, Professor Geoffry Dobb, Dr Liz Feeney, Dr Iain Dunlop, Dr Stephen Parnis, and Dr Steve Hambleton

Dr Hambleton with AMA Queensland President Dr Christian Rowan (right), with Greenslopes Private Hospital CEO Mark Page , Dr Jim Houston Director of Medical Services and, Carmel Monaghan Marketing & Public Affairs Manager)

The World Medical Association General Assembly in session, Fortaleza, Brazil

Dr Hambleton on ABC 24

Dr Hambleton with Dr Liz Marles RACGP President (left) and Dr Eleanor Chew

AMA Council of General Practice

Offshore nip and tuck a risky cut: AMA

The AMA has raised concerns about a plan by one of the nation's largest health insurers to offer packages for patients to have cosmetic surgery and other medical procedures performed overseas.

The Australian newspaper has revealed that health fund NIB has developed plans to cash in on the medical tourism market, providing packages for customers who want medical work done at a cheaper price offshore, particularly Asia.

NIB Managing Director Mark Fitzgibbon told the newspaper that, from next year, customers would be able to buy packages for cosmetic surgery and dental work to be performed by doctors in Malaysia, Indonesia and other Asian countries.

"We're building a medical travel business here," Mr Fitzgibbon told The Australian. "We don't like the word 'tourism' – we think that has the wrong connotations. We will provide you with the opportunity to relax and recuperate at a nice resort, maybe, but it's not a holiday."

According to the paper, NIB will offer packages that include flights, accommodation, treatment and a concierge to make arrangements. The packages will not be restricted to NIB members.

Mr Fitzgibbon said the packages would include assurances regarding safety and quality.

But AMA President Dr Steve Hambleton said there were significant concerns about the standard of care patients would receive.

Dr Hambleton said that medical training and accreditation standards in Australia were among the most stringent in the world, and although there were some excellent surgeons in Asia, there were not the same system-wide assurances of the quality of care.

The AMA President said those considering going offshore for medical treatment should take into account more than just the price.

"It's not just the price. It's really the follow-up, it's really the quality, and it's really all of those other things that wrap around [it]," Dr Hambleton told ABC radio. "It's probably a truism, that you do get what you pay for."

He said there were multiple requirements and standards that meant the quality of care provided in Australia was world-class, including post-operative care in the event of complications.

"You can get treatment right here and be pretty confident that you're going to get high standards of medical practitioners," Dr Hambleton said. "Our training is very, very high in terms of world standards. You know that the hospital you go to is accredited, and that it has good infection control systems, and those are at a world standard."

The AMA President said it was also important to look at why people wanted to have cosmetic surgery, whether it be in Australia or overseas.

He said there was a preoccupation, including among young men and women, with having the "perfect" face or figure, and "we need to think about their body image issues. Maybe the right answer is to say, 'You don't need the surgery at all. This isn't going to solve your problem'."

Adrian Rollins

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Free urological advice for GPs

General practitioners are being offered free, practical advice on how to assess patients who may be at risk of prostate cancer at a joint University of Melbourne-Austin Hospital symposium.

The one-day Urology in General Practice symposium, being held at Melbourne's Grand Hyatt Hotel on 9 November, addresses a number of urological issues commonly encountered in general practice, including the vexed issue of when to test for prostate specific antigen (PSA), and how to interpret and act on the results.

Convenor Professor Damien Bolton, Director of Urology at Austin Hospital, said GPs and patients were being confronted with a multitude of guidelines on PSA screening that made it particularly confusing.

"It is hard to expect a patient to make an accurate judgement on a health test when medical practitioners continue to disagree on when to apply it," Professor Bolton said. "The symposium will provide actionable guidance for GPs on the use of PSA. There is a need to separate testing and diagnosis of prostate cancer from subsequent aggressive treatment."

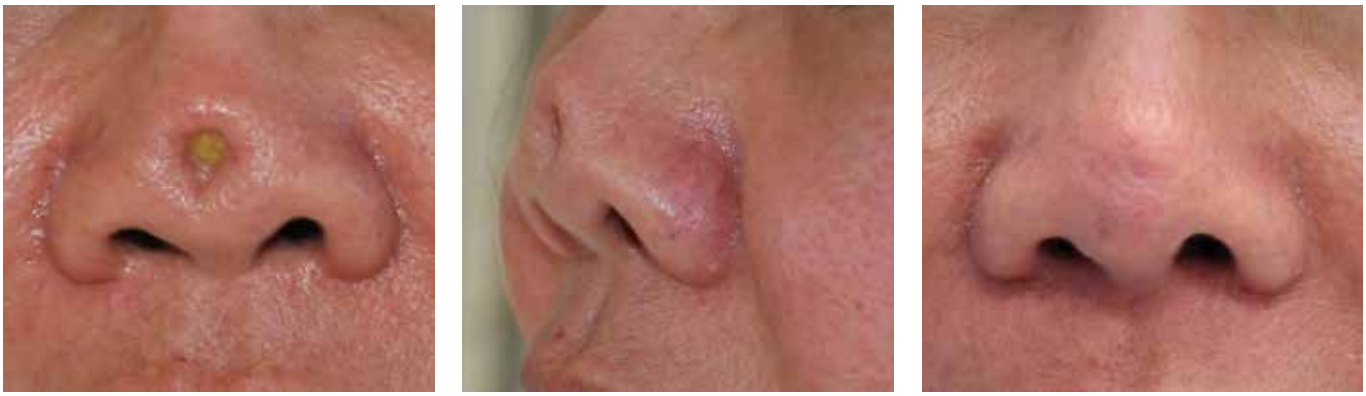
He said the PSA test was not really useful for men younger than 45 years and older than 75 years, and a number of biomarkers, including the Prostate Health Index (PHI), had been developed to confirm the need for a biopsy where PSA has been found to be elevated.

"PHI provides a clear indication of the risk of prostate cancer in patients," Professor Bolton said. "The test is relevant for patients where the PSA is high, where there is a family history of prostate cancer, or where an earlier biopsy is negative but PSA continues to rise. PHI can indicate which patients will be best served by biopsy."

The symposium will also include sessions on the use of green light lasers as an alternative to transurethral resection of the prostate, as well as new therapies for treating premature ejaculation and the management of symptoms of benign prostatic hyperplasia.

To register, go to: www.urogp.com.au

The ugly side of medical tourism



A woman with a badly disfigured nose following cosmetic surgery in Thailand (left and centre), and following restorative surgery by Dr Nicholas Moncrieff (right)

For surgeon Dr Nicholas Moncrieff and his colleagues at Hunter Plastic Surgery, the sight of women disfigured by botched cosmetic operations overseas is a distressingly common one.

Almost every week the clinic, based in Charleston, just outside Newcastle, gets a new patient upset with the results of sub-standard procedures that have left them with collapsed noses, scarred faces, misaligned breasts and nipples or skewed belly buttons.

Among recent cases was a 40-year-old woman who went to Thailand for cosmetic surgery, including the insertion of a silicon implant in her nose to give it more projection.

It subsequently became badly infected and exposed, leaving her with a serious defect (see picture above).

Dr Moncrieff had to operate on her in hospital to remove foreign matter, repair the hole and use filler to fill the cavity.

The surgeon said the vast majority of such cases involved patients who had gone to Thailand for cosmetic surgery, lured by cheap prices.

In Thailand it typically costs around $4000 to $6000 to have breast augmentation surgery, compared with $11,000 at Hunter Plastic Surgery.

But Dr Moncrieff said people who chose where to have surgery based simply on price did not fully realise the sort of risks they were taking.

“I think it [plastic surgery] has been a little trivialised because it has become commonplace,” he said. “This is surgery, it is still an operation on your body, and people think it’s like a haircut.”

Often, cosmetic procedures performed overseas are much more radical than clinics like Hunter Plastic Surgery would undertake, such as inserting very large breast implants in women with small frames, leading to complications such as sore backs or infection because sutures are put under enormous strain.

Dr Moncrieff said any surgery, no matter where it was performed, carried with it the risk of complications, but when it was conducted overseas the burden for rectifying any mistakes fell on the Australian health system.

He said patients were often told by their Thai doctors that any complications could be addressed for free in Australia under Medicare, and public hospitals in his area regularly had to treat women who had become badly infected following cosmetic surgery performed overseas.

But he warned that this did not extend to rectifying elective cosmetic problems, such as facial scarring or nipples in the wrong place.

As an example, the woman who had to have her botched nose surgery repaired spent more than $3000 on the repair work – far more than it would have cost to have the procedure performed locally in the first place. She was able to claim back just $750 of the cost through Medicare.

Dr Moncrieff said it could cost up to $19,000 to repair botched breast augmentation procedures, a sum that was prohibitively expensive for many women who had had such work overseas in the first place because of price, and who usually had no private health cover.

He said in this instance, they often had to live with the disfigurement until they could save the money to have it repaired, either in Australia or in the country where the procedure was originally carried out.

Dr Moncrieff said his concern with the cosmetic tourism trade was not driven by self-interest – “we are plenty busy enough without having to fix these problems” – but by the burden it was placing on taxpayers and the health system.

“We think the Australian Government should be asking questions about how complications will be managed [under the NIB scheme] once the patient is back in Australia and who will be paying for them, especially those treated for life-threatening illnesses in public hospitals” he said.

Adrian Rollins

TO COMMENT CLICK HERE

Trust a casualty in television show stunt

When a young man professing to be tired and stressed walked into the consulting room of Dr David Chambers on 1 October and asked for a medical certificate, the Brisbane GP took his patient at his word and began trying to delve into reasons for his condition.

During the consultation, the man – who was accompanied by a woman – said he was fatigued and, according to Dr Chambers, looked anxious and avoided eye contact.

Little did Dr Chambers know that he was being secretly filmed as part of a set-up by the Channel Nine television show *A Current Affair* for a story intended to show that doctors readily issued medical certificates to patients who simply wanted a day off work. The patient was in fact a producer from the program, as was the woman who accompanied him.

When the story was broadcast the following night, the 16-and-a-half minute consultation - in which Dr Chambers made a thorough examination of his patient, took a full history, organised for blood tests to be taken if the professed fatigue persisted, and discussed mental health issues – was edited down to a brief grab intended to justify the story's premise.

Dr Chambers was among five GPs caught up in the *ACA* sting, and although their faces were disguised in the story that went to air, he found that both colleagues and patients quickly recognised him.

Aside from the anger he feels about being "hugely misrepresented" by the program, Dr Chambers worries about the corrosive effect this and similar programs might have on the crucial doctor-patient relationship.

"Doctors are rightly held to high moral and ethical standards, treating patients with respect and trust, and protecting their privacy," he said. "But it is also incumbent upon the patient to be truthful with the doctor.

"Most of what we do is based on good history taking, and we rely on patients being honest with us. We are not mindreaders.

"If you don't have that trust, then everything is lost."

Dr Chambers said programs like the *ACA* segment had the potential to be "quite destructive, because they devalue that relationship".

It is a concern shared by AMA Council of General Practice Chair Dr Brian Morton, who said that trust and honesty were paramount in the relationship between doctors and their patients.

"Our profession expects honesty from our patients. Communications between the patient and the doctor involve honesty from the patient and, reciprocally, from the doctor," Dr Morton said. "We cannot mistrust what the patient is saying."

The importance of this was underlined, he said, by the experience of a colleague who treated a patient complaining that they were hearing a cricket in their ear. Rather than dismiss the complaint as a case of tinnitus, the doctor made an examination and found that there actually was an insect inside the man's ear.

Commenting on the premise of the *ACA* report, Dr Morton said medical certificates were legal documents, and doctors did not issue them lightly.

But equally, they were not simply for physical maladies, as the television show seemed to imply.

Dr Chapman said he had treated a number of young men with depression who had presented with symptoms similar to those described by the *ACA* producer, and was alert to the possibility his patient was suffering mental health problems.

Dr Morton said often doctors had to use judgement and care in what they wrote on medical certificates.

He said privacy considerations and stigma surrounding conditions such as mental illness or sexually transmitted infections meant it was not unreasonable for doctors to talk with their patients about what should be included when writing a certificate.

Dr Morton admitted that he did, on occasion, come under pressure from patients to issue a certificate, either claiming to be suffering a cold or even not providing any medical reason for their absence from work.

"In this situation, it behoves me to make a medical examination, take a history, and come to my own conclusion," he said. "Doctors are expected to take a professional and legal view."

The egregious shortcomings of the *ACA* report – which included file footage of Dr Morton without indicating to viewers that it was from an interview given more than two years ago – were highlighted by ABC's *Media Watch* program on 14 and 21 October.

Dr Chambers provided an account of his experience to *Media Watch*, and has written a formal complaint to Channel Nine.

Adrian Rollins

TO COMMENT CLICK HERE

Thousands forego vital cancer screen

Thousands of breast cancers are going undetected because more than a million women each year fail to have a mammogram.

Breast screening figures released by the Australian Institute of Health and Welfare show that 45 per cent of women aged between 50 and 69 years did not have a free mammogram in 2010-11, meaning that potentially more than 3000 breast cancers went undetected.

Though many women, particularly those who live in remote areas, are Aboriginal or Torres Strait Islander, or do not speak English as a first language, still are not being regularly screened, the program has nonetheless saved thousands of lives through the early detection of the deadly cancer.

All up, 1.3 million women – 55 per cent of the target 50 to 69 year age group – were screened for breast cancer in 2010-11, and the disease was detected in around 290 of every 100,000 people examined.

Significantly, screening has proven to be effective at detecting breast cancer at an early stage of development, when treatment is likely to be most effective.

The Institute found that in half of all cases where cancer was detected in women being screened for the first time, it was small (less than 15 millimetres in diameter), and among those with cancer being screened a second time or more, the detection rate was even higher – 63 per cent.

The significance of early detection is that it greatly increases the likelihood of effective treatment and survival.

According to the report, *BreastScreen Australia Monitoring Report 2010-11*, 61 per cent of breast cancers detected by the program are small, compared with less than 30 per cent of those diagnosed in other circumstances.

The success of the program has been underlined by figures showing that, since free breast screening was introduced in 1991, the breast cancer mortality rate has fallen from 68 per 100,000 women to 43 per 100,000.

"This has been largely attributed to the early detection of cancers through screening practice, along with advances in management and treatment," the Institute said.

Despite advances in detection and treatment, breast cancer still claims hundreds of lives every year. In 2010, 1098 women aged between 50 and 69 years died from breast cancer, making it the second-most common cause of cancer-related death after lung cancer.

Public health experts have expressed particular concern about the relatively low rates of breast cancer screening among Aboriginal and Torres Strait Islander women. In 2010-11, just 36 per cent of Indigenous women in the target age group had a mammogram, compared with 54 per cent of those from other backgrounds.

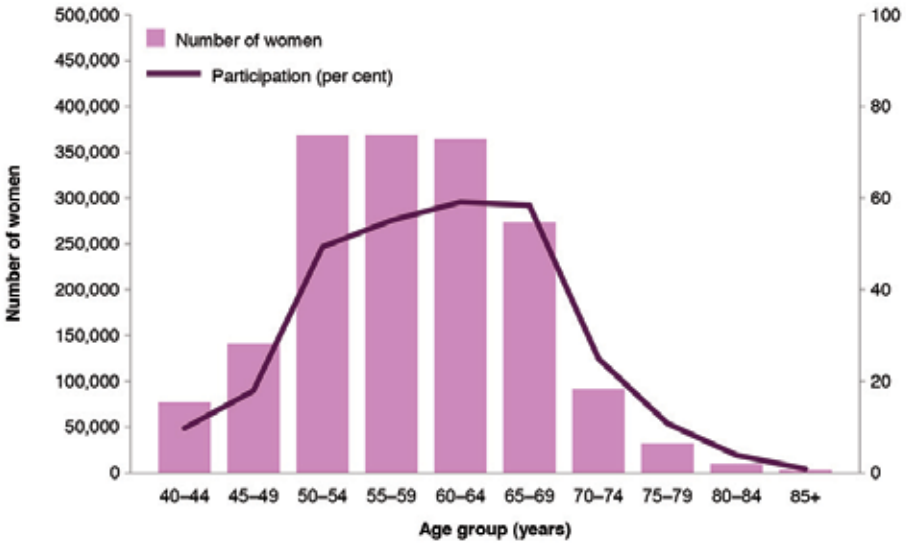
A booklet designed to help inform and support Indigenous women about breast cancer, including its detection, treatment and follow-up care, was last week launched by Health Minister Peter Dutton.

Mr Dutton said breast cancer was the most commonly diagnosed cancer among Indigenous women, and they currently faced significantly worse survival prospects compared with the broader community.

"Between 2006 and 2010, Aboriginal and Torres Strait Islander women had lower five-year crude survival for breast cancer than non-Indigenous women – 69 per cent and 83 per cent respectively," the Minister said.

He said the booklet *My Breast Cancer Journey: a guide for Aboriginal and Torres Strait Islander women*, had been developed by Cancer Australia with funding from the Commonwealth to help improve those odds.

Adrian Rollins



Note: The data for this graph are in *BreastScreen Australia monitoring report 2010–2011: supplementary data tables.*

Source: AIHW analysis of BreastScreen Australia data.

Figure 1.1: BreastScreen Australia participation by age group, females, 2010–2011

TO COMMENT CLICK HERE

Nation switches off solariums

Commercial sunbeds are set to be banned virtually nationwide by 2015 after Queensland and Western Australia indicated they would join other states and territories in outlawing commercial solariums.

In a move welcomed by doctors and anti-cancer groups, Queensland Health Minister Lawrence Springborg and WA Health Minister Dr Kim Hames last month announced that their governments were moving to prohibit commercial UV tanning products, bringing them into line with similar measures in New South Wales, Victoria, South Australia, Tasmania and the Australian Capital Territory.

Mr Springborg said his State had not issued any new licences for commercial sunbeds since late last year, and Queensland's 44 existing licensed operators have been given 14 months' notice of a full ban, to come into effect from December 31, 2014.

In WA, Dr Hames told Fairfax radio he was formulating a similar policy that would be presented to State Cabinet within three months.

"I have to take it to Cabinet, but if it happens it will happen in the next three months," Dr Hames said. "There is no doubt about the increased risk of cancer - so I think the chances are [a ban in WA] won't be far away."

The moves mean that soon the Northern Territory will be the only jurisdiction in Australia where commercial solariums and sunbeds are not banned.

The dangers of using sunbeds and solariums have been known for more than 10 years.

In 2000, the US Department of Health listed solariums as a known human carcinogen linked to malignant melanoma of the skin and eye.

A systematic review of research on the link between skin cancer and solarium use, published in the *British Medical Journal* last year, concluded any sunbed use increased the risk of melanoma by 20 per cent, and raised it by three times that amount of the exposure was before 35 years of age. Furthermore, the risk increased with each sunbed session.

The Cancer Council has warned that "solariums are not a safe way to tan, and can result in serious damage to your skin".

"Just like the sun, solariums emit UVA and UVB radiation, which can damage skin and cause skin cancer. UV radiation from solariums can be just as intense, if not more so, than natural light," it said.

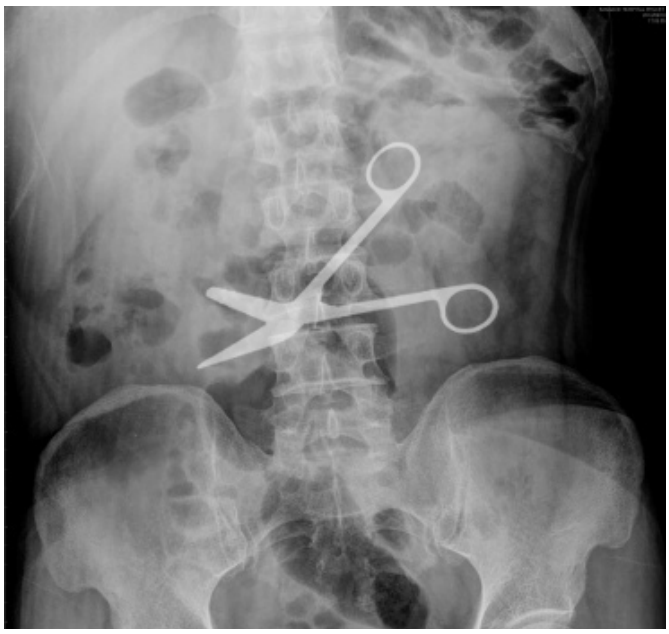
The health risks associated issue of solariums gained national prominence in 2007 when 26-year-old Clare Oliver, suffering end-stage melanoma, delivered a heartfelt public warning on the made an advertisement warning of the dangers of tanning, including through the use of commercial sunbeds.

The following year, the Victorian Government introduced laws to regulate the industry before moving to a full ban, to take effect from 31 December next year.

Adrian Rollins

TO COMMENT CLICK HERE

Medical errors will cost major hospital operator



A major private hospital operator has agreed to forgo payment from insurer Bupa if any of its members are harmed by serious medical errors at any of its institutions.

In an agreement lauded as setting a new quality benchmark for care in the private hospital system, hospital operator Healthscope and Bupa have agreed on a list of 14 medical errors, dubbed 'never events', that should not occur.

Under the terms of the agreement, when a never event involving a Bupa member does occur, and is found to be the hospital's fault, the health fund will withhold payment.

The types of error covered by the agreement include patients being transfused with the wrong blood, surgery being conducted on the wrong body part, a medication error resulting in serious disability, or surgical instruments or medical supplies being left in the body, requiring follow-up surgery to remove it.

Healthscope Managing Director Robert Crooke said his company was confident in the quality of care it provided, and the agreement set a framework which could eventually lead to reward payments for above-standard care.

"Never events are essentially the reverse of being paid for quality," Mr Cooke said. "If a never event occurs in a Healthscope hospital, and it is due to hospital error, then we do not expect to receive payment from Bupa. We are prepared to stand by our commitment to quality and safety."

Bupa Chief Medical Officer Dr Paul Bates said the agreement with Healthscope was an important innovation in lifting the standard of care.

"This shared commitment leads the industry in terms of improving hospital outcomes for patients, which is something the industry has grappled with for many years," Dr Bates said.

Mr Cooke said the agreement with Bupa provided a blueprint that could be adopted across the private health sector.

"There is currently no industry-wide agreement on what should happen in the rare instance when a never event occurs," he said.

"We hope that this agreement will drive change and set a precedent for the consistent provision of health care.

So-called never events are rare, but their effects can be devastating for patients and their families. A similar scheme in the United States found that 0.6 per cent of all hospital patients suffered such an error in their care, and a 2006 study estimated that such mistakes cost the country more than $2.2 billion a year.

A Productivity Commission report found that in 2010-11, there were 26 incidents in public hospitals where surgical instruments or materials were left in the body of a patient and had to be retrieved, as well as 13 instances where the wrong medication was given to a patient, resulting in their death. Other serious errors included operations on the wrong part of the body, intravascular gas embolisms, and suicides of hospital inpatients.

Health Minister Peter Dutton told *The Australian* he welcomed the initiative, which should serve as an example to others in the private health industry.

"I think it brings pressure on to the other providers to be more transparent in the data that they release," Mr Dutton said. "If we can bring that pressure to bear on both the public and private systems, we will end up with better health outcomes."

The Healthscope-Bupa agreement came as more than 50 leading international health care providers, suppliers and operators urged the universal adoption of the GS1 System of Standards as the global benchmark for the health care supply chain.

GS1 is a not-for-profit global standards organisation supported by an international network of health and medical manufacturers, suppliers, providers, industry associations and regulatory bodies, and is intended to develop and implement uniform global standards governing the manufacturing and distribution of health and medical supplies.

Adrian Rollins

TO COMMENT CLICK HERE

New course charted in embolism treatment

Practitioners will be prompted to assess the blood clot risk of patients in an update to standardised inpatient medication charts.

As part of efforts to reduce the incidence of hospital-associated venous thrombo-embolism (VTE), the Australian Commission on Safety and Quality in Health Care has decided to incorporate a form on the condition in the National Inpatient Medication Chart (NIMC), following a two-year pilot study.

The Commission's Chief Executive Officer, Professor Debora Picone, said the pilot study had found a significant improvement in documenting the risk of VTE and appropriate prescribing when a chart on the condition was included in the NIMC.

The chart is designed to prompt and document VTE risk assessment and contraindications, as well as record any drugs or mechanical aids ordered or administered.

Its incorporation in the NIMC is seen as an important step in improving the identification of VTE risk and its treatment.

The NIMC is a standardised set of medication charts that ensure a consistent format for patient information shared between health workers practitioners.

It was introduced in 2006 as part of a national strategy to cut down on medicine errors in acute care, and its use in mandatory in hospitals accredited under National Safety and Quality Health Service Standards.

Under the change, all short-stay NIMCs for adult inpatients, (including a version designed to be incorporated in GP electronic prescribing software for inpatients prescribed medicines by a GP), will include the VTE chart.

A modified version of the prophylaxis section of the chart, which only includes space for documenting the assessment of VTE risk and contraindications, will also be included in the outpatient version of the NIMC.

Professor Picone said the VTE chart would not be included in the long-stay NIMC for stable, acute adult inpatients, nor in the long and short-stay version of the NIMC for paediatric patients.

Copies of the new NIMC can be downloaded from:

www.safetyandquality.gov.au/our-work/medicatioon-safety/medication-chart/

An online training guide for use of the NIMC is at:

www.nps.org.au/health-professional/professional-development/online-learning

Adrian Rollins

TO COMMENT CLICK HERE

Sex diseases rise as men play casual

There has been a big upsurge in the prevalence of sexually transmitted diseases in a sign that the safe sex message is wearing off.

Figures presented to the Australasian Sexual Health Conference late last month showed that diagnoses of gonorrhoea, syphilis and HIV infections have jumped to their highest levels in years, prompting concerns that a growing number of younger people are putting themselves and their partners at risk by having unprotected sex.

The number of gonorrhoea diagnoses soared to 13,649 cases last year, driven by a three-fold increase in New South Wales, more than double in Victoria and a 53 per cent jump in Queensland.

Syphilis infections have also risen, with 1534 cases diagnosed last year, close to the all-time high.

Adding to public health concerns, figures simultaneously released at the Australasian HIV & AIDS Conference showed there were 2153 new HIV diagnoses in 2012 – the largest number of new cases in 20 years.

Associated Professor David Wilson of the Kirby Institute said the rise could not be put down to better testing alone.

"Some of the rise in reported HIV diagnoses may be due to an increase in testing, but better testing simply cannot explain the magnitude of these rising rates," Associate Professor Wilson said.

Increases in the incidence of HIV, gonorrhoea and syphilis have coincided with evidence that an increasing number of gay men are having unprotected sex.

A study by the Centre for Social Research in Health at the University of New South Wales found that almost 40 per cent of gay men with casual partners had unprotected anal intercourse in the preceding six months - up from less than 32 per cent in 2003 and 38 per cent in 2012. This behaviour was found to be particularly prevalent among men younger than 25 years.

"The rise in unprotected sex with casual partners has been occurring gradually over the last decade, and we're now at the highest level ever recorded in our surveys of gay and bisexual men," Centre director Professor John de Wit said.

Professor de Wit linked the rise in unprotected sex among younger men to findings that they were less likely to have been exposed to HIV prevention campaigns.

Adrian Rollins

TO COMMENT CLICK HERE

Bishop anointed for life-saving work

A medical researcher who pioneered the discovery and treatment of a deadly virus that kills hundreds of thousands of children every year has received a top science award.

Professor Ruth Bishop, who is based at the Murdoch Children's Research Institute in Melbourne, has been awarded the CSL Florey Medal in recognition of her decades of work identifying, understanding and treating the deadly rotavirus, which is estimated to cause the deaths of around 450,000 children every year.

In 1973, Professor Bishop and her colleagues at the Royal Children's Hospital and the University of Melbourne's Department of Microbiology were the first in the world to discover rotavirus, an infection of the lining of the upper small intestine in young children that interferes with the body's ability to absorb fluids, causing dehydration. Around 1200 children die from the disease every day.

Through decades of painstaking and determined research, Professor Bishop and her colleagues isolated the virus, examined how it spread and developed vaccines.

In Australia, a rotavirus vaccine was added to the National Immunisation Program for infants in mid-2007, and the number of hospitalisations caused by the infection has plunged by more than 70 per cent since.

The vaccine is now being rolled out in some of the world's poorest countries, through the Global Alliance for Vaccines and Immunisation and the Bill and Melinda Gates Foundation.

Early results from Bolivia, the first low-income country to take part in the expanded program, show a 75 per cent drop in hospitalisations due to rotavirus infection.

A more advanced vaccine is currently being trialled in Indonesia and New Zealand.

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."

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

Intact PIP implants given qualified all-clear

A high-level European scientific committee has found that there is no convincing reason for PIP breast implants to be removed unless they have ruptured.

In a conclusion that brings to end a string of inquiries and reports on the implants, which were subject to a worldwide recall after it was discovered they were being manufactured using substandard silicone, the European Commission's Scientific Committee on Emerging and Newly Identified Health Risks found that there was no "convincing medical, toxicological or other data to justify removal of intact PIP implants as a precautionary approach".

The Therapeutic Goods Administration said the finding was in line with its own assessment and, while it would continue to monitor failure rates of the implant, it was not planning any further investigations.

According to figures collected by the TGA, there were 490 confirmed ruptures of PIP implants, and a further 24 unconfirmed ruptures, as of 10 October.

The regulator said it had been found that PIP implants had higher concentrations of several cyclic siloxanes than other silicone breast implants, but they were non-toxic and were not shown to be an irritant.

"Neither implant rupture, nor local inflammation, has been found to be associated with breast cancer or anaplastic large cell lymphoma," the TGA said. "While there are differences in rupture rates, there is no reliable evidence that ruptured PIP implants create a greater health risk than a ruptured silicone implant from another manufacturer."

Nonetheless, the regulator "strongly advised" that where rupture occurred, the implant be removed, adding that widespread concern regarding undetected ruptures meant "there is a need for women with PIP breast implants to seek regular clinical examinations".

Adrian Rollins

TO COMMENT CLICK HERE

Vital thyroid drug rationed as global shortage bites

Access to a potentially life-saving thyroid treatment has been severely restricted following a global shortage of the medicine.

The Therapeutic Goods Administration has warned doctors and patients that they could face lengthy delays in getting access to the drug Carbimazole, marketed under the name Neo-Mercazole as a treatment for overactive thyroid, following a breakdown in the global production and supply of the medication.

The TGA has restricted access to the drug until an alternative supply of a generic Carbimazole product becomes available from around the middle of the month.

The regulator has advised patients using the drug to make an appointment with their doctor at least two weeks before their supply runs out.

In order to ration existing stocks of the medicine, it has been placed under a special access regime.

Where doctors assess that their patient is seriously ill, or is reasonably likely to die within a matter of months, they can apply for immediate access to the drug under Category A of the Special Access Scheme.

In order to do this, they must complete a Category A form, which is sent to both the TGA and a pharmacist. The pharmacist will send a copy to the supplier (Link Healthcare), who will approve supply.

The TGA has warned that supply of the drug for all other patients (designated as Category B) can take up to 10 working days.

In this instance, a doctor will have to fill out a Category B form, which is then sent to the TGA for consideration, a process that is currently taking up to 10 working days to complete.

If approved, a letter will be sent by the TGA to the doctor, pharmacist and Link Healthcare, and the latter will approve the supply of the medicine to the patient.

The regulator said these processes were a temporary measure that would be lifted once the alternative generic product became available from around mid-November.

Adrian Rollins

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

AMA List of Medical Services and Fees - 1 November 2013

The 1 November 2013 edition of the AMA List of Medical Services and Fees will soon be available both in hard copy or electronic format.

Members listed as being in private practice or with rights of private practice should receive their hard copy no later than 31 October 2013. Salaried members who have ordered a hard copy should also receive their copy by 31 October 2013.

The AMA Fees List Online (**http://feeslist.ama.com.au/**) will be updated as at

1 November 2013. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

Electronic versions (PDF or CSV) of the AMA List will also be available for free download from the Members Only area of the AMA Website (**www.ama.com.au/feeslist**) from 22 October 2013.

A Fees Indexation Calculator is also available for members to calculate their own fee increase based on their individual cost profile.

To access this part of the website simply enter your username and password in the box on the right hand side of the screen and follow these steps:

1) Once you have entered your login details, from the home page hover over Resources at the top of the page.
2) A drop down box will appear. Under this, select **AMA Fees List**.
3) Select first option, **AMA List of Medical Services and Fees - 1 November 2013**.
4) Download either or both the **CSV** (for importing into practice software) and PDF (for viewing) versions of the AMA List.
5) For the Fees Indexation Calculator, select option **15**. **AMA Fees Indexation Calculator.**

Members who do not currently have a username and password should email their name, address and AMA member services number to **memberservices@ama.com.au** requesting a username and password.

If you do not receive your hard copy of the 1 November 2013 AMA List of Medical Services and Fees or would like one, please contact the AMA on **02 6270 5400**.

Health on the hill

Political news from the nation's capital

Wait ends for diabetic children

Health Minister Peter Dutton has released almost $1 million earmarked by the previous Government to help fund insulin pumps for children in lower-income families.

In one of his early acts as Minister, Mr Dutton has signed a contract with the Juvenile Diabetes Research Foundation (JDRF) to supply insulin pumps to 204 families with children who have type 1 diabetes.

The move has ended months of uncertainty for the families, after former Health Minister Tanya Plibersek announced in July that an extra $870,000 had been allocated to the program, under which the Commonwealth covers up to 80 per cent of the cost of insulin pumps for eligible families.

So far, 439 children with type 1 diabetes have been provided with insulin pumps through the scheme, which provides assistance to families with an annual income less than $101,653.

The funding increase was put on hold when the Federal election was declared and the Government entered caretaker mode, and Mr Dutton admitted the delay has caused stress for the families involved.

"I know that parents were upset at the delay in this funding, and I wanted it sorted," he said. "It will at least be one less worry for families under enormous pressure. Some of these families have been on a waiting list for over a year. They've waited long enough for access to this life changing technology."

Insulin pumps liberate children with type 1 diabetes from the need to be injected with insulin up to four times a day. Instead the pump, which is a small computerised device, provides a slow, continuous feed of rapid acting insulin throughout the day, delivered through a tiny tube under the skin.

The pumps are expensive, typically costing between $4000 and $8000, and under the scheme the Government provides means tested subsidies ranging from 10 to 80 per cent of the cost of a pump (capped at $6400) for families with an annual income between $69,496 and $101,653.

Adrian Rollins

TO COMMENT CLICK HERE

Medibank sale could force up premiums: AMA

The AMA has flagged concerns that the Abbott Government's proposed sale of Medibank Private could result in higher health insurance premiums for families because of increased commercial pressure and a potential reduction in competition.

Acting on long-standing Coalition policy, Finance Minister Mathias Cormann late last month initiated work on privatising Medibank, the nation's largest private health insurer, with estimates the sale could deliver at least $4 billion to the Government's bottom line.

But AMA President Dr Steve Hambleton has raised fears that the sell-off could potentially hurt patients, and called for close scrutiny of the terms of any proposed sale.

Ever since legislation authorising the sale was proposed in 2006, the AMA has voiced concerns that the privatisation of Medibank Private will lift premiums and leave families worse off.

Dr Hambleton said there were three specific areas of concern regarding the proposed sale.

Firstly, if Medibank Private (which is the biggest health fund, with close to 30 per cent of the market) was sold to another health fund it would severely curtail competitive pressure.

Secondly, premiums could be forced higher as private owners sought a quick return on investment to help service the equity needed to fund the purchase, with the risk increasing the higher the purchase price.

Thirdly, that Australian policyholders could be heavily exposed to international financial risk if the buyer is an offshore entity, as could well be the case.

Dr Hambleton said that the sale could also drive premiums up faster by removing the moderating influence of Government from a part of the market.

...CONTINUED ON PAGE 23

Health on the hill

Political news from the nation's capital

...CONTINUED FROM PAGE 22

"We are concerned that competition needs to be maintained in the private health [market], and Government owning Medibank Private has kept costs down," the AMA President said on ABC radio. "We…wonder whether it will actually decrease the amount of pressure on private health insurers to keep their prices down."

His warnings were echoed by Shadow Health Minister Catherine King, who said taxpayers should be concerned about the sale plan.

"It's up to Government to explain how the sale of Medibank Private will benefit Australians, and whether they'd sit idly by and watch health premiums rise as a result," Ms King said.

But Senator Cormann dismissed such concerns, telling *The Australian Financial Review* that "whether in private or public hands, Medibank operates under the same laws and regulatory environment as all other health insurers".

Since the sale was first mooted nine years ago, estimates of the likely sale price have doubled, from $2 billion to $4 billion, though market analysts have warned the Abbott Government may struggle to get much more than that unless changes are made to private health insurance policies.

Nomura analyst Toby Langley told *The Australian Financial Review* that the insurer would have to demonstrate a credible long-term growth story to the market in order to bump up the potential sale price.

Mr Langley said measures like means testing of the private health insurance rebate and the removal of the rebate from lifetime health cover loading had created uncertainty about the potential for growth in private health insurance cover, making it "quite an awkward time" to be putting a health fund on the market.

In a move that could increase investor interest, Treasurer Joe Hockey has flagged the possibility that Medibank Private could take over responsibility for administering the National Disability Insurance Scheme.

While the sale of Medibank Private is Government policy, Senator Cormann told the AFR its privatisation was not inevitable, and would depend on achieving the best deal for taxpayers.

Senator Cormann has directed the Finance Department to commission a three-month scoping study of the sale looking at the sale method, timing, cost, regulatory issues, possible return and the readiness of Medibank Private for sale.

The study is due to begin by the end of the month and be completed by the end of February next year, so that the transaction could be included in framing the 2014-15 Federal Budget.

"There is no compelling policy reason for the Government to continue to own Medibank," the Finance Minister said, "[and its] privatisation would remove the current conflict where the Government is both the regulator of the private health insurance market, as well as a large market participant."

Senator Cormann said the proceeds of the sale could be used to fund other policy priorities or reduce overall Government debt.

Dr Hambleton said the AMA would be guided in its view on the sale by the results of the scoping study and the degree to which it addressed the Association's concerns.

Adrian Rollins

TO COMMENT CLICK HERE

Giving NDIS to Medibank a risk: AMA

The AMA and disability groups have raised concerns about suggestions that health insurer Medibank Private be given responsibility for administering the National Disability Insurance Scheme.

According to *The Australian Financial Review*, Treasurer Joe Hockey and Finance Minister Mathias Cormann are considering tendering out some administrative functions of the National Disability Insurance Agency as a way to cut down on duplication of bureaucratic operations, and have suggested they could be taken over by Medibank Private.

But AMA President Dr Steve Hambleton said the health fund's recent record did not inspire confidence in its ability to administer such an important scheme.

Dr Hambleton said the performance of Medibank Private's offshoot Medibank Health Solutions in managing a $1.3 billion contract to provide health services for Australian Defence Force personnel raised significant concerns about how well it would manage the NDIS.

"We've had concerns with the way it was set up, and we've had some feedback from our members who are concerned about the way it's running," he told the *AFR*. "There were some difficulties with accessing sufficient numbers of people in various areas of the country, there were some issues with preferred providers which, according to feedback from our members, has delayed access to care in some cases."

The Combined Pensioners and Superannuants Association of New South Wales said any move to put management of the NDIS in the hands of Medibank Private would be a "huge loss" for people with disabilities.

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"People with disabilities and their carers have been waiting for far too long for adequate support services, and to be told that the overarching scheme may be placed within a health insurer that's to be sold off is abhorrent," the Association's Senior Policy Officer, Amelia Christie, said. "If the Abbott Government is adverse [sic] to multiple bureaucratic bodies, why would they not place the responsibility for the NDIS within Medicare rather than with a body that they intend to privatise?"

But Assistant Minister for Social Services, Senator Mitch Fifield, said there was no cause for alarm.

Senator Fifield said "there may be some functions of the National Disability Insurance Agency that…could be contracted out through a competitive process. Businesses and not-for-profits could tender for such business, if it was offered".

"New service providers are emerging, and it may well be that Medibank Private chooses to offer services in this market. That is a matter for them," he said.

Shadow Minister for Disability Reform, Jenny Macklin, said the Government's comments showed people with a disability were right to be very concerned.

Ms Macklin said it was extremely important that the NDIS was operated by an independent authority, in order to make sure it was administered in the interest of people with a disability.

She called on the Government to immediately confirm that it would not "tamper" with the NDIS.

Adrian Rollins

TO COMMENT CLICK HERE

No extra funds for research

Prime Minister Tony Abbott has warned that there will be no additional funding for medical research as the Commonwealth focuses on containing health spending.

But Mr Abbott has vowed the Government will push ahead with promised reforms to National Health and Medical Research Council grants, including introducing a screening process to weed out unlikely applications at an early stage, and increasing the length of grants.

The Prime Minister made the comments while announcing the award of almost $560 million for grants approved by the NHMRC. He said there had been more than 5000 grants applications, of which 963 (19 per cent) were successful.

There was no increase in funding beyond that already provided for by the out-going Labor Government, but Mr Abbott said the

Government remained committed to support health and medical research.

"The Government is determined to do everything that we reasonably can, even in these fiscally challenged times, to ensure that Australia's health and medical research effort continues," he said.

"At this point in time, we don't have additional funding, [but] there's a lot of work that we are going to do, even within the current fiscal envelope."

By research area, cancer claimed the largest share of funding, with projects receiving almost $128 million. The next largest amount, $70 million, was for cardiovascular disease, while mental health projects shared $60 million, diabetes $45 million, injury $41 million, Indigenous health $32 million, obesity $24 million and dementia $22 million.

Adrian Rollins

TO COMMENT CLICK HERE

Government pumps up PBS

The Abbott Government has moved to fast-track the approval of subsidies for medicines that have been recommended for PBS listing by medical experts.

In a break with practice under the previous Labor Government, Health Minister Peter Dutton has announced that he will have authority to directly approve the listing of drugs that will cost less than $20 million a year to subsidise.

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Health on the hill

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Under Labor, recommendations for drugs to be listed on the PBS had to go before Cabinet for approval, prompting complaints of unnecessary delays in giving patients subsidised access to lifesaving medicines.

Mr Dutton said the changes introduced by the Government would speed approvals for medicines that had received a positive recommendation for funding from the Pharmaceutical Benefits Advisory Committee.

In 2001, the Howard Government established a $10 million threshold for medicines that could be listed on the PBS by the Health Minister, and Mr Dutton said the current Government had not only restored the threshold, but increased it, in order to give patients access to new and improved medicines "sooner and at an affordable price".

The move followed an announcement earlier last week in which treatments for cancer, diabetes and multiple sclerosis were among 50 new and upgraded medicines approved for subsidy by the Federal Government.

Health Minister Peter Dutton has announced that about 230,000 Australians will be able to cheaply access advanced drugs for treating a range of serious and debilitating conditions after they were added to the Pharmaceutical Benefits Scheme on 28 October.

Among the medicines to receive a subsidy is the melanoma treatment Dabrafenib, a drug that targets the genetic mutation that is present in about half of all melanoma cases.

Mr Dutton said that, to support its use, the Government would also provide subsidised access, through the Medicare Benefits Schedule, to the genetic test necessary to determine eligibility for Dabrafenib.

"This means the costs for both the medicine and the genetic test will be subsidised, and will benefit more than 800 Australians," the Minister said.

The Government has also approved subsidies for the pancreatic cancer treatment Sunitinib, which increases survival rates of patients who cannot undergo surgery, and for extending the use of the osteoporosis medicine Denosumab to men.

In addition to the new listings, the Government has also approved price changes for a number of medicines on the PBS, but Mr Dutton assured patients that despite the changes they would have to pay no more than $36.10 per prescription, or a maximum of $5.90 for pensioners.

Adrian Rollins

TO COMMENT CLICK HERE

Health spending in frame as beancounters let loose

Health bureaucrats and agencies are set to come under scrutiny from the Federal Government's Commission of Audit as it searches for ways to cut back on Commonwealth spending.

While Prime Minister Tony Abbott has promised there will be no overall cuts to the $64 billion health budget, the Commission – headed by Business Council of Australia President Tony Shepherd - is expected to hone in on what it sees as duplication in the administration of health care, with agencies such as the Australian National Preventive Health Agency, the National Health Performance Agency and the Australian Institute of Health and Welfare expected to be in the frame.

If the Audit is sufficiently ambitious, it is likely to also closely examine the role played by the Commonwealth in delivering health care.

In its terms of reference, it has been asked to uncover "areas or programs where Commonwealth involvement is inappropriate". Combined with the Prime Minister's assurance that "nothing is off limits", it opens the way for a thorough dissection of the role the Federal Government plays in the health system.

The Labor Government instituted a series of reforms intended to bring national consistency to the cost of health services by introducing activity based funding. This was supported by a number of agencies setting and affirming quality standards and measuring the delivery of health services.

Health Minister Peter Dutton has said he backs the activity based funding system and values the collection of accurate health care data, raising questions about the extent to which the Commission of Audit can identify areas of duplication that can be axed without compromising the shift toward a uniform national system of funding.

The AMA has already nominated one area – the PBS authority prescription system – where it thinks significant savings can be made.

The Abbott Government's commitment to sustaining the overall level of health funding has been leant credence by a number of recent announcements that have involved the disbursement of significant funds, including adding 50 new and upgraded medicines to the PBS, streamlining the approvals process for listing medicines on the PBS, and unveiling medical research grants worth more than $500 million.

Adrian Rollins

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Reform can fix health gap

BY **PROFESSOR IAN RING**

Professor Ian Ring, Professorial Fellow at the Australian Health Services Research Institute, University of Wollongong, suggests the review of Indigenous funding being headed by Tony Mundine, Chair of the Federal Government's Indigenous Advisory Council, could pave the way for real improvements in Aboriginal health.

This article was first published in The Canberra Times on 28 October, 2013.

A recent episode of Q&A echoed traces of the widespread view that much money has been spent on Aboriginal health and other matters, with relatively little to show for it - and that the money must have been eaten up by a bloated bureaucracy, was misdirected, or corruptly or incompetently used.

All of these may be true, but only to a very limited extent. The reality is that, until recently, the Federal Government, through its own programs, was spending less per capita on Aboriginal health than it was on the rest of the population - despite Aboriginal people being at least twice as sick.

That changed with the introduction of the National Partnership Agreements (NPAs) involving the Commonwealth and all State and Territory governments, which injected $1.6 billion into Aboriginal health and $4.6 billion over four years to 2012-13 into health, education, housing, employment and remote services as part of the Closing the Gap programs. Australia went from having a degree of international opprobrium because of its neglect of Aboriginal issues to becoming internationally competitive in terms of indigenous policy and funding.

But what results have we seen from this allocation of additional funds? In a four-year program, the funds start out at low levels in the first year and build up progressively over the next three. The funds then need to be used to employ people, who need to be recruited and trained, and then it takes more time for the programs in which they work to become fully effective.

Taking the $100 million allocated to smoking, for example, the very earliest we could hope to see any kind of significant change in smoking would be picked up by the next smoking surveys, the results of which will be available next year.

Given the lag between smoking reduction and improvements in smoking-related diseases, the earliest we could see measurable changes in heart and lung mortality may not be until 2020.

The apparent lack of progress from data currently available tells us about the lack of progress before the additional $1.6 billion hit the ground and is just what we would expect to see at this stage, rather than indicating a waste of funds or a misallocation of resources.

But was the money optimally allocated? Almost certainly not, and for reasons that are crying out to be dealt with by the Mundine review. The programs funded by the NPAs all made sense individually but, collectively, they missed the point, and in no sense approximated the comprehensive long-term action plan promised in the statement of intent. The problem was not in the policy determined by governments, or in the funding, but in the bureaucratic implementation of those policies.

The programs were determined by officials in State and Territory governments with insufficient genuine consultation with the people who run the Aboriginal community controlled health services (ACCHS).

Nobody seemed to have asked that, if we want to halve the child mortality gap in 10 years and the life expectancy gap in a generation, what services do we need to achieve those goals?

And nobody seems to have wondered how it was possible to have healthy mothers and babies, and to get on top of chronic diseases, without adequate provision for mental health services.

The limited evidence available clearly shows that ACCHS run by and for Aboriginal people eclipse mainstream general practice in the identification of risk factors, performance of health checks, care planning and the management of Aboriginal and Torres Strait Islander patients.

So, instead of asking what services would produce the best return on investment, the decision seems to have been taken to allocate new funds to perpetuate current patterns of use between mainstream and ACCHS health services.

Too many senior officials still cling to the notion that in Australia's cities and towns mainstream services are the answer - in the absence of evidence that this is so, and in the face of evidence that it isn't. There is a real risk that mainstreaming will be seen as some kind of solution, when the reality is that there needs to be sensible arrangements for mainstream and ACCHS services to work together, as in the Urban Indigenous Health Institute.

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Reform can fix health gap

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While current levels of indigenous health funding go a long way to redressing the previous shortfall in health expenditure, estimated by health economists at about $500 million a year, inequities in the share of mainstream program funding received by Aboriginal people is still an issue.

So what does this mean for the Mundine review and the new Government? Three issues stand out.

First, bureaucratic reform is essential. That means substantially fewer public servants, but those that remain need to have the requisite skills and experience. There is broad agreement that the main functions of Aboriginal health should remain with the Department of Health, preferably led by an Indigenous official. But a small, high-level group in the Department of the Prime Minister and Cabinet, to ensure that the new Prime Minister's requirement to deliver for Aboriginal people is met, is an essential component of the new arrangements.

Second, the recently formulated National Aboriginal and Torres Strait Islander Health Plan isn't really a plan in any meaningful sense, but could become one if the implementation plan foreshadowed in it is developed in genuine partnership with Aboriginal people, and involves officials with the requisite skills, experience and training. But that implementation plan needs to also include mental health and, this time, to wrestle successfully with mainstreaming.

Third, and most important, it is time for Aboriginal communities to play a more central role in the design and conduct of their own services, bearing in mind that some of the best health services in Australia are run by the ACCHS sector.

If the Mundine review and the Abbott government can successfully address these issues Australia, in the not too distant future, could complete the long transition from international opprobrium to leading the world in Indigenous health.

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Letter

Dear Editor

In our column this month, AMSA has shared medical students' opinion on the topical issue of conscientious objection. We note that the AMA has written about it, too, specifically in regards to the *Reproductive Health (Access to Terminations) Bill 2013* in Tasmania ('Abortion law must respect dictates of conscience', August 12).

The AMA asserted that, "Under the proposed law, failure to [refer] would constitute a criminal offence." A scary prospect, but AMSA has examined the clause notes accompanying the Bill, and we quote: "Failure to [refer] may result in professional sanctions for medical practitioners, while counsellors face a maximum fine of 250 penalty units [$32,500].

"The different consequences for non-compliance reflect that, unlike medical practitioners, counsellors are not regulated by professional boards established under national laws for regulating health practitioners."

That is, for doctors, the Bill actually prescribes no penalty at all, which we hope brings the AMA some relief.

Benjamin Veness
President
Australian Medical Students' Association

A GPs work is never done

BY **DR BRIAN MORTON**

"When setting their fees, GPs need to consider all that is involved in providing quality patient care, and value that work appropriately"

New data collected by the BEACH (Bettering the Evaluation and Care of Health) program highlights the amount of time GPs spend on non-Medicare Benefit Schedule (MBS) billable work.

This research is welcome, as it is provides some hard and reputable data on the time GPs spend on patient care outside of the face-to-face consultation.

The AMA has long had the view that non-contact care is often an underestimated and undervalued element of general practice, and in early 2011 asked BEACH to collect data on this aspect of GP work. We wanted reliable data that would highlight the fact that there is so much more to patient care than what the patient sees and what the Medicare rebate covers. We wanted to be able to have that unseen work quantified.

The data gathered by BEACH is a great start, but it is just the tip of the iceberg. Results from the AMA 2011 Red Tape survey showed that, on average, GPs spent 4.6 hours a week on red tape, with some spending up to 9 hours per week.

While the BEACH data provides an overview across general practice, there are days where you can spend up to three hours on non-Medicare billable work for patients, such as completing a myriad of forms that keep bureaucrats employed, coordinating care, and sitting on the phone waiting for a desk clerk give the authority to prescribe. From the findings of the Red Tape survey, the AMA has estimated that time that could be spent providing an extra 15 million consultations a year is lost because of time spent on such administrative tasks.

As evidenced by the BEACH study, red tape accounts for the largest portion of doctor time spent on work that is not face-to-face. Not only does this reduce the time GPs have available for seeing patients, it also has potential consequences for doctor health if this work is done outside of the normal working day.

I have no doubt that the $15,000 BEACH estimates GPs lose through providing unpaid care is far short of the mark, given most GPs do not charge what they are worth.

Nevertheless, having hard data that corroborates what all GPs know, and have been saying for years, about the extra time they put in to support patient care and ensure access to needed services, is welcome. Not only will it add weight to AMA advocacy, I hope it will act as a reminder to GPs that they provide a service that is more valuable than the Medicare rebate reflects - a rebate that has failed to keep pace with the costs of providing medical care and continues to undervalue the worth of GPs.

When setting their fees, GPs need to consider all that is involved in providing quality patient care, and value that work appropriately.

The AMA provides members with a Fees Calculator, which is a valuable tool to assist them in determining, based on their own cost experiences, how much to adjust their fees. If we are providing quality care to our patients, we should be comfortable putting an appropriate value on that care.

I hope that this research gives GPs more confidence when it comes to explaining to their patients that a fair and reasonable fee reflects all that goes into providing and managing their medical care. It should also signify to patients who do pay a co-payment that they are paying for more than just face-to-face time with their GP.

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What happens when we disagree with our patient

BY **AMSA PRESIDENT BEN VENESS**

"In the case of having a conscientious objection, some doctors do not want to write a formal medical referral to a colleague"

You probably remember from your own uni days, medical students don't always agree with patients, either. Sometimes, a patient's wishes conflict with our nascent medical judgement, our personal conscience, or both.

The latter conflict was considered at AMSA's recent Council Meeting, where we adopted the *Conscientious Objection and Access to Care Policy* (2013), available at www.amsa.org.au.

AMSA's policy recognises that doctors have a right to exercise a "conscientious objection", and are free to refuse to provide any non-emergency services to which they conscientiously object. However, patients rely on us to provide impartial information so that they may make an informed choice as to which option is best for them. Exercising a personal objection must not infringe the patient's right to be provided with information about, and access to, all available management options.

AMSA believes that denying or impeding access to such information is contrary to the Medical Board of Australia's Code of Conduct and is, in any case, inappropriate.

This is a hot topic because of a piece of draft legislation currently before the Tasmanian Parliament, and because of a decision by a Melbourne GP that is being investigated by the Medical Board.

Clause 7 of the *Reproductive Health (Access to Terminations) Bill 2013* (Tas) says that, "…if a woman seeks a termination or pregnancy options advice from a medical practitioner and the practitioner has a conscientious objection to terminations, the practitioner must refer the woman to another medical practitioner who the first-mentioned practitioner reasonably believes does not have a conscientious objection to terminations."

AMSA supports this subclause, but the AMA does not.

Another disputed area pertains to the word "refer".

In the case of having a conscientious objection, some doctors do not want to write a formal medical referral to a colleague.

AMSA believes that the clause notes allay this concern: "It will be up to the medical practitioner and counsellor to decide how to refer – neither will be obliged by this clause to write a written referral detailing the patient's medical history as one might do with a referral to a specialist – instead it will be sufficient if the woman is provided with the name and contact details of an alternative provider who does not have a conscientious objection."

It is pertinent that the referral is to another practitioner who the first practitioner knows does not have a conscientious objection. This aims to ensure the patient receives timely and accurate information on any procedure he or she may desire.

In major cities it would hopefully be possible to go directly to such a person, but in regional areas with few GPs, placing such an obligation on all practitioners may make a big difference to patients.

Section 8 of the *Abortion Law Reform Act* 2008 (Vic) imposes similar requirements on doctors as the aforementioned Tasmanian Bill.

Even though a doctor may disagree with abortion, for example when an abortion is requested because of the fetus's gender, a refusal to refer may constitute a breach of the Act. AMA (Victoria) has suggested that to prevent this problem, doctors with conscientious objections place a tactful notice in the waiting room and on their website. It is important to remember that providing a referral to a colleague who is willing to discuss all available options does not necessarily mean a woman will persist with her initial request for an abortion.

AMSA believes that a doctor should have a right of conscientious objection. AMSA also believes that the exercise of an objection must not, directly or indirectly, impede a patient's access to care. Where a course of management for a patient is legal, any doctor who holds a conscientious objection to the provision of such management should declare their objection to their patient, and provide an effective referral to another health practitioner who does not hold such an objection.

AMSA supports clause 7 of the Tasmanian Bill and section 8 of the Victorian Act, and would be grateful for the AMA to join us. Let's make it simple: be impartial, or refer.

Benjamin Veness is the president of the Australian Medical Students' Association. He is studying medicine and a Master of Public Health at The University of Sydney. Follow on Twitter @venessb and @yourAMSA

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Grattan Institute ideas detached from reality

BY **DR DAVID RIVETT**

"So, facing reality, these proposals are basically to provide rural Australians with fragmented, lower quality care - most likely at a higher cost"

The Grattan Institute report *Access all areas: new solutions for GP shortages in rural Australia* finds what many other studies have also concluded, that limited access to GP care is leading to worse outcomes for rural Australians.

Well and good, but one wonders just how many such reports have to be produced before much needed meaningful and lasting solutions are enacted by an enlightened Government acting in concert with the profession. The solutions proposed by this report are half-baked, and are likely to only lower standards of care.

Its suggestion that pharmacists could reduce GP workload by taking over some tasks, such as immunisation, is cloud cuckoo land stuff.

GPs invest considerable resources in maintaining a cold chain, and in employing nursing staff to provide vaccinations under supervision. To transfer this service to pharmacists would make the ongoing provision of vaccinations by GPs unviable. Additionally, it would fragment care and record keeping. To justify such a change by arguing that pharmacists need a new source of revenue because of the terms of the PBS agreement re-negotiated by the Federal Government is not a sound reason for putting such theorems forward.

Involving pharmacists in chronic disease management would be a step forward for patients, rural or urban, but only as part of a practice team - not as an independent practitioner. If done in a quality manner, it would likely reduce hospitalisations from both iatrogenic causes and the exacerbation of chronic conditions, and save the Government large sums in PBS expenditure. However, it would require a team approach and increased, not decreased, GP time.

Physicians' assistants can be a useful adjunct to the practice team, but two major barriers stand to their utilisation. Firstly, the training system is already stretched to capacity coping with the influx of medical students coming through the pipeline. Under current funding restrictions there is just not the room to create a new area of education. Secondly, access to Medicare rebates is restricted to the providing doctor, which militates against the employment of physicians' assistants.

Furthermore, I have yet to see any evidence that physicians' assistants would be more cost effective than well-trained rural GPs. I have, however, seen plenty of evidence that independent nurse practitioners are more expensive than GPs.

So, facing reality, these proposals are basically to provide rural Australians with fragmented, lower quality care - most likely at a higher cost.

After all the woeful press about politicians attending the footy, cricket and car racing - as well as the odd wedding - at considerable cost to the public purse, the previous Government's decision to impose a $2000 cap on tax deductions for self-education expenses seems even a greater nonsense. Its introduction has been delayed until mid-2015, but it must be thrown out. It will, if enacted, hit all rural doctors hard. It is indeed pleasing to see the AMA championing this fight, as well as providing a sound, multifaceted package of workable rural workforce solutions.

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Are doctors obliged to heed disaster's call?

BY **DR LIZ FEENEY**

Last month's bushfires in NSW are a timely reminder for members to consider whether you are prepared to respond to a major public health emergency such as a natural or man-made disaster, disease pandemic, or even terrorist activity, whether in Australia or overseas.

There are many aspects to disaster and pandemic preparedness that require appropriate education, training, guidance, and support; for example, specific knowledge and skills are required to understand how to mobilise, triage, organise, and manage mass casualties, often with limited resources.

But such preparedness also requires personal reflection on the many ethical challenges that arise in times of major public health crises that do not generally occur during regular, day-to-day clinical practice.

You may find your duty to protect and care for an individual patient comes into greater conflict with your duty to protect others including patients, staff, colleagues, and the wider community. Just as important, you have a personal and professional duty to protect yourself from harm and a personal duty to your own family.

Consider the following questions that could well arise in a major public health emergency:

- are you willing to risk your own health and wellbeing to care for patients?
- Are you willing to put your family at risk in order to care for patients?
- What are the reasonable bounds of personal risk you are willing to accept?
- Is it reasonable to assume the full-fledged participation of the medical profession in responding to such a crisis?
- Should doctors have an absolute duty of care in such situations? and
- What should happen to those who choose not to respond?

Doctors face difficult personal and professional challenges when responding to a public health emergency, including greater professional duties; increased occupational risks; physical and emotional stress; isolation from colleagues, family and friends; professional liability risk; loss of income; discrimination and possibly stigmatisation; risk of personal injury, illness, and death; and the possibility of exposing family members and others to increased risk of personal illness, injury, and death.

The AMA's Ethics and Medico-Legal Committee (EMLC) is currently reviewing the *AMA Position Statement on Ethical Considerations for Medical Practitioners in Public Health Emergencies in Australia*, and we are interested to hear your views on the limitations (if any) to a doctor's duty of care during such events.

SARS, Bird Flu, Hurricane Katrina, the 2004 Boxing Day and Japanese tsunamis, the events of 9/11 in the United States – unfortunately, horrible, catastrophic events happen, and the medical profession, like many other professions, will be called upon, and indeed expected, to respond in the immediate aftermath.

Don't wait until something happens to decide what you would do. It's time to think about these issues now, reflect on them, and consider your response. Are you prepared? Are you willing?

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Nominations for admission to the AMA Roll of Fellows

By-Law 16 enables Federal Council of the AMA to admit members nominated by a Committee of Fellows to the AMA Roll of Fellows.

Any ordinary member of the AMA may nominate a member of the Association who has given outstanding service to the AMA and has had 10 years uninterrupted membership (or shorter period if considered exceptional by Federal Council) and merit special recognition.

A nomination for admission to the AMA Roll of Fellows must be accompanied by a written citation setting out the particulars of the services given to the Association by the member and for which it is considered the member merits admission to the Roll. The nomination should be sent via email to nsharpe@ama.com.au, followed by a hard copy to the Secretary General, AMA, PO Box 6090, Kingston ACT 2604, to be received no later than 31 December 2013.

Nominations of Fellows must be treated in strictest confidence. Only under exceptional circumstances may the nominated Member be informed, and then only by the President of the nominating body or, if relevant, the Federal Councillor representing a nominating Craft Group or Special Interest Group.

A Fellowship Committee of Federal Council, appointed by the President, will consider the nominations.

Anne Trimmer
Secretary General
29 October 2013

Young Government poses fresh challenges for healthy ageing priorities

BY **DR RICHARD KIDD**

The recent change of Government heralds some interesting changes for aged care.

Health care for Australia's ageing population did not feature particularly strongly during the 2013 election campaign, despite the AMA's attempts to spark debate with the release of its *Key Health Issues* document, and calls for increased funding and Medicare rebates for medical services provided for dementia, palliative and aged care patients.

Many have been left wondering what the Government's overarching vision is for aged care after it unveiled the new-look Ministry for Health and Sports and announced that aged care would be relocated into the ever-expanding Department of Human Services.

An indication of where the Government stands on aged care can be found in the Coalition's policy *Healthy Life, Better Ageing*, released in September. In this document, the Coalition pledges it will use the Productivity Commission's *Caring for Older Australians* report to guide future policy.

It commits an additional $200 million over five years for dementia research, and sets out a plan to reduce regulation, cut red tape and prioritise future reform by negotiating a five-year Healthy Life, Better Ageing Agreement with the aged care sector. The document has a clear focus on supporting reforms that will streamline and strengthen the aged care health sector.

Encouragingly, the new Government has also indicated they will support the continuation of many reforms in the *Living Longer Living Better* aged care package, including flexible arrangements for living in the community, and workable standards.

Above all, the Coalition's *Healthy Life, Better Ageing* policy document suggests a the Government will adopt a consultative style in relation to aged care issues. In this environment, the AMA will to continue to call for a review of the Medicare Benefits Schedule to support the assessment and management of dementia in primary care, and to reflect the complexity of providing care to older Australians in aged care facilities and the community.

The real fear for aged care, however, is that without a dedicated Minister there is the potential for a lack of attention and a lack of dedicated resources for specific aged care issues.

The new administrative arrangements for health and aged care pose new challenges to the Committee for Healthy Ageing. We will need to look for opportunities to work with the restructured federal Ministry to keep the priorities of the ageing population on the national health agenda.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Research

Thousands of teens infected by unprotected sex

Tens of thousands of adolescent girls and boys, many of them as young as 12 years, are infected with a serious sexually transmitted disease that can cause infertility.

Research presented to the Australasian Sexual Health Conference late last month showed that chlamydia, a bacterium that can cause pelvic inflammatory disease in women and urethritis in men, has become the most commonly reported disease in the country, with 82,707 cases diagnosed last year.

But lead researcher Professor David Wilson, from the Kirby Institute, cautioned that the number of undiagnosed cases was probably far higher, and could amount to more than 400,000 people carrying the infection.

"It is likely that there are five times more Australians with chlamydia that is undiagnosed, who may be at increased risk of infertility and other reproductive health problems," Professor Wilson said.

In a particularly worrying assessment, he warned that as many as one in every 20 young people aged between 15 and 24 years have chlamydia – a claim supported by the findings of a separate study conducted by the Burnet Institute that find high rates of chlamydia positive tests in young teenage girls.

Drawing on data from more than 286,000 chlamydia tests conducted by 15 laboratories between 2008 and 2010, the researchers found that 13 per cent of girls aged between 12 and 15 years were diagnosed with chlamydia – the highest proportion of positive tests of any age group.

By comparison, 12 per cent of girls aged between 16 and 19 years had the disease, and 8 per cent of women aged between 20 to 24 years.

The surprising result has been described as a wake-up call for health authorities and parents about the rate of sexual activity among young adolescents, and the risks that many are running by having unprotected sex.

But lead researcher Carol El-Hayek hastened to add that the relatively high proportion of 12 to 15 year-old girls who tested positive for chlamydia most likely because those tested displayed symptoms or were seen as being at sexual risk, whereas tests were more routine for girls and women in the older age groups, and were likely to involve more negative results.

Among males, the proportion of positive chlamydia tests was highest for boys aged between 16 and 19 years (15 per cent), compared with 9 per cent for those in the 12 to 15-year age group, and 13 per cent among men aged 20 to 24 years.

"Clearly, Australian adolescents as young as 12 are vulnerable to sexually transmitted diseases, but the younger they are, the less likely they are to be tested," Ms El-Hayek said. "We need a better understanding of the sexual risk practices of young people in order to minimise their risk and ensure they have access to testing and treatment."

Adrian Rollins

TO COMMENT CLICK HERE

Women doctors outperform the men

Patients who want better care should seek out a woman doctor rather than her male colleagues.

That, at least, is the conclusion of a Canadian study examining the treatment provided by 870 Quebec practitioners coordinating care for elderly diabetic patients.

Researchers from the University of Montreal monitored the billing patterns of the doctors, assessing the quality of care provided by reference to guidelines for the clinical treatment of diabetes issued by the Canadian Diabetic Association.

According to the guidelines, all patients aged 65 years and older must:

- undergo an eye exam by an ophthalmologist or optometrist every two years;
- receive three prescriptions for specific drugs including statins; and
- undergo a complete medical examination annually.

The researchers found that, among middle aged doctors, 75 per cent of female doctors referred their patients to undergo an eye examination compared with 70 per cent of male doctors; 71 per cent of female doctors prescribed recommended medications

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compared with 67 per cent of male doctors, and 39 per cent of female doctors asked their patients to undergo a complete examination, compared with 33 per cent of male doctors.

However, male doctors were found to conduct 1000 more procedures a year than their female colleagues.

Lead researcher Valerie Martel said women has significantly higher scores in terms of compliance with practice guidelines, and that they were more likely than men to prescribe the recommended medications and plan required examinations.

"My hypothesis was the differences between male and female practices have diminished over time," Ms Martel wrote. "It seemed to me that more and more men are taking time with their patients at the expense of productivity, and more and more women tend to increase their number of procedures. This aspect was shown. The younger the doctor, the less significant the differences [between the genders]."

Professor Regis Blais, who oversaw the study, said that people assume women doctors spend more time with their patients than their male counterparts, but this was difficult to observe in scientific study.

Instead, he said, there were other aspects of care that needed to be taken into account.

He said that while a more productive doctor – one that saw more patients within a given time frame - would seem more profitable for a hospital, there was a bigger picture.

"Doctors who take the time to explain problems to their patients may avoid these patients returning after a month because they are worried about detail. The more productive physicians may not be the ones we think," Professor Blais said.

Kirsty Waterford

TO COMMENT CLICK HERE

Experts recommend pap smear overhaul

A top-level committee of medical experts has told the Government it should subsidise the use of a much-improved method of screening for cervical cancer.

The powerful Medical Services Advisory Committee (MSAC) has recommended that the cell enrichment liquid-based cytology (CE LBC) technique be adopted for routine screening for cervical cancer, and that the procedure be added to the Medicare Benefits Schedule, meaning doctors will receive a rebate for carrying out the test.

Like a conventional pap smear, CE LBC involves using a brush or spatula to collect cells from the cervix. But in the new technique, the head of the brush or spatula is either rinsed into, or broken off into, a vial of preservative fluid, creating a cell suspension which is then sent to a laboratory.

In this direct-to-vial collection method, instead of smearing the cells directly onto a glass slide, cells collected from the cervical scraping are transferred directly to the CE LBC preservative fluid.

When at the laboratory, the CE LBC cell sample is treated to remove obscuring factors such as blood, mucus and inflammation, so that a thin layer of cervical cells can be placed on a slide for microscopic examination.

MSAC said this technique had a number of advantages over the conventional pap smear method of diagnosis because it reduced the number of blood cells, inflammatory cells and non-diagnostic cellular debris in the sample, improving the quality, quantity and viability of the cells for examination in the laboratory.

The Committee recommended the Government publicly fund CE LBC through the Medicare Benefits Schedule.

Kirsty Waterford

TO COMMENT CLICK HERE

A bat of the lashes could be toxic

For most women, applying two coats of mascara on their eyelashes every morning before heading out the door is standard.

But most may not be aware that the product that gives them dark and luscious eyelashes might also contain mercury.

In late October, more than 140 countries signed the United Nations' Minamata Convention, which includes a ban on mercury in cosmetics and soaps.

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However, mascara and other eye makeup products have been exempted from the protocol because, the UN said, "no effective safe substitute alternatives are available", and "the intention [of the Convention] is not to cover cosmetics, soaps or creams with trace contaminants".

Dental fillings are also exempt from the treaty, but its authors have stressed the importance of reducing their use by promoting better oral health and developing more non-mercury alternatives.

Mercury is a potent neurotoxin, and high levels can cause serious neurological effects and kidney damage. The Convention is named after the Japanese city of Minamata, where mercury from a local chemical plant accumulated in fish and shellfish and poisoned inhabitants, killing almost 2000 and leaving thousands more physically maimed.

To date, no studies have examined the effects of exposure to the low concentrations of mercury found in mascara or other eye makeup, but the toxin is known to be absorbed through the skin.

Mercury is used in mascara to prevent bacterial growth that could cause infections in the eye, and it also acts as a preservative. The United States Food and Drug Administration allows mercury in cosmetics as long as the concentration remains below 65 parts per million.

Joanna Tempowski from the World Health Organization's International Program on Chemical Safety told *Scientific American* that the purpose of using mercury in eye makeup was to inhibit the growth of bacteria and fungi that could spoil the products and that could infect and damage the eye, so the risk-benefit analysis favoured its use.

But Stacy Malkan, co-founder of the advocacy group Campaign for Safe Cosmetics, said there was no reason that "a known neurotoxin should be allowed in any of these products". She said many US companies have developed alternative, non-mercury-based preservatives.

The treaty's focus was to phase out cosmetics that used mercury in larger concentrations to lighten the skin. Studies have shown that, in these products, the toxin can be absorbed through the skin, potentially leading to kidney damage.

Sheila Logan, a program officer with the United Nations' Mercury and Other Metals team, told *Scientific American* that when the treaty's cosmetics ban goes into effect in 2020, there will probably be few or no products containing mercury. She said alternatives do exist for some mascaras, but not for all.

The treaty also takes aim at industrial air emissions containing mercury, banning and delaying mercury mines, and regulating small-scale gold miners who use the element. As well as cosmetics, the production, import, or export of many mercury-containing products will also be banned by 2020. The list includes mercury in electrical switches and relays, most batteries, many lamps and bulbs, medical items like thermometers and blood pressure devices.

Kirsty Waterford

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Guide for Practitioners: Notifications in the National Scheme

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

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

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

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

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

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

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

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

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

Consent no placebo for medical research

The world's peak doctor association has tightened rules governing medical research and condemned the use of chemical weapons and the criminalisation of homosexuality.

The World Medical Association General Assembly, meeting in Fortaleza, Brazil, has issued a revised Declaration of Helsinki setting out more stringent ethical principles to guide clinical trials, as well as adopting resolutions regarding the use of chemical weapons and the treatment of homosexuality as a medical disorder.

"In particular, the Assembly took issue with the persistent portrayal of homosexuality as a disease, and associated practices and policies that seek to "convert" homosexuals"

The Assembly, attended by former AMA Presidents Dr Mukesh Haikerwal and Dr Andrew Pesce, adopted tough new rules intended to ensure medical research was conducted in an ethical manner consistent with the Declaration of Geneva, which requires that the health of patients will be a physician's primary consideration.

In the ninth revision to the Declaration of Helsinki since it was first adopted in 1964, the WMA has imposed new and additional obligations on researchers to safeguard the interests of research subjects.

Under the new provisions, every research study involving human subjects must be registered in a publicly accessible database before any subjects are recruited, and researchers have a duty to make the results of their study – included any negative or inconclusive findings – publicly available.

Under the new rules, research must only be carried out using vulnerable groups where the study is being conducted in response to the health needs of these groups and cannot be carried out using a non-vulnerable group.

The Declaration also demands that there be "appropriate compensation and treatment for subjects who are harmed as a result" of taking part in medical research.

Dr Pesce said the Assembly held lengthy discussions about the ethics of using placebos, as opposed to the best currently available treatment, in clinical trials.

Ultimately, it was decided that the use of placebos could be justified, but only in particular circumstances.

Under the provisions of the revised Declaration, the effectiveness of any new treatment must be tested against of the best proven interventions, except where no proven intervention exists, where there are "compelling and scientifically sound methodological reasons" for using a placebo, or where using a placebo will not expose test subjects to "additional risks of serious or irreversible harm" as a result of not receiving the best proven intervention.

In addition to ethical rules guiding medical research, the Assembly debated the portrayal of homosexuality as a disease or criminal behaviour in many countries.

In a statement issued following the discussion, the WMA strongly condemned all forms of stigmatisation, criminalisation and discrimination based on a person's sexual orientation.

In particular, the Assembly took issue with the persistent portrayal of homosexuality as a disease, and associated practices and policies that seek to "convert" homosexuals.

"Homosexuality itself is not a disease," WMA President Dr Margaret Mungherera said. "It is the stigmatisation and discrimination experienced by people with a bisexual or homosexual orientation which can be harmful to health.

"So-called 'conversion' or 'reparative' therapies exacerbate these negative health effects, and represent unethical practice.

"Therapies which claim to be able to convert homosexuality into asexual or heterosexual behaviour have no medical indication, involve questionable methods, and must be denounced as unethical."

Dr Pesce said the motion faced vigorous opposition from associations based in African, Asian and Middle Eastern countries, but was supported by a wide range of delegates, including those from Russia and the Vatican.

The Assembly also passed a motion condemning the use of chemical weapons. But Dr Pesce said it was only endorsed after references to specific countries were removed because of objections from Russia and Japan.

Motions on the role of physicians in identifying children the victims of illegal adoption and child trafficking, the commercialisation of reproductive material and the involvement of physicians in screening participants in reality television programs have been referred to national medical associations for further consideration.

Adrian Rollins

TO COMMENT CLICK HERE

Global vaccination effort saves millions

The lives of up to 10 million children could be saved in the next six years by joint action to boost vaccination rates in developing countries, according to the Global Alliance for Vaccines and Immunisation.

In its Mid-Term Review, presented to a meeting in Stockholm last week, the Alliance (GAVI) reported good progress in boosting immunisation rates in developing countries, with 97 million children receiving GAVI-funded vaccines in 2011 and 2012, potentially saving around 1.1 million lives.

The Alliance – which is a public-private partnership founded by the Bill and Melinda Gates Foundation, the WHO, UNICEF and the World Bank - said that developing countries were on track to immunise an extra 243 million children through GAVI-supported routine immunisation programs between 2011 and 2015, preventing almost four million future deaths.

Looking further ahead, it said expanded vaccination programs in developing countries had the potential to save 10 million lives, prevent more than 200 million cases of illness, and avert more than $US200 billion in illness-related costs by 2020.

Since 2011 the Alliance has overseen the introduction of vaccines on 98 separate occasions, including almost 30 launches of the pneumococcal vaccine and the introduction of rotavirus vaccines on 10 occasions.

Earlier this year it begun funding for the human papillomavirus vaccine and the combined measles-rubella vaccine.

But it admitted that poor infrastructure, inadequate transport networks, funding constraints and soaring demand meant the organisation was likely to fall short of the targets it had set itself for the five years ending 2015.

The lack of a well-functioning and reliable refrigerated supply system in

many countries increased the risk that vaccines would be exposed to damaging temperatures before they could be used. The vast majority of vaccines need to be kept at between 2 and 8 degrees Celsius before they are administered.

The Alliance has also encountered difficulties in its efforts to build up the capacity of countries to sustain immunisation programs once GAVI support is withdrawn, though it reported that 17 countries are on track to meet co-financing requirements, and seven are expected to be in a position by 2015 to support ongoing vaccination programs without external assistance.

But the humanitarian organisation Medicins Sans Frontieres (MSF) has called on GAVI to do more to improve vaccination rates in developing countries.

Executive Director of the MSF Access Campaign, Dr Manica Balasegaram, said that although the organisation fully supported GAVI's mission, "we think that [it] could improve its work in a number of areas so that more children can be protected from childhood killers".

Specifically, MSF believes the Alliance needs to cut the cost of vaccination by driving a harder bargain with manufacturers and suppliers, and the give humanitarian organisations such as MSF access to these vaccines at a cheaper price (currently access is restricted to Alliance members, such as participating governments).

MSF said the cost of fully vaccinating a child had soared since 2001 from $US1.38 to $US38.80, and concern was mounting among many countries where MSF is active that "they will not be able to afford these prices once they lose GAVI support".

The humanitarian organisation also wants GAVI to extend its vaccination programs to include children older than 12 months, and tho provide incentives for the development of vaccines – such as the MenAfriVac meningitis A vaccine – that can survive for lengthy periods without refrigeration.

It said cold chain logistics were often incredibly difficult in developing countries, where power supplies were often unreliable or virtually non-existent, and temperatures regularly exceeded 40 degrees Celsius.

"We think it's very important for GAVI to take a close and critical look at what it can improve," MSF Vaccines Policy Adviser Kate Elder said.

In its update, GAVI said that the development of new vaccines against HIV and tuberculosis were still some time off, but added there was "a very real prospect" of a malaria vaccine within the next five years, while an inactivated polio vaccine would be introduced into routine immunisation programs in coming months.

Adrian Rollins

TO COMMENT CLICK HERE

Doctors sentenced to life for hep C outbreak

A doctor in the United States has been sentenced to life in prison after being found guilty of involvement in a deadly hepatitis C outbreak.

News service AAP has reported that former endoscopy clinic owner Dr Dipak Desaia, 63, was found guilty of 27 criminal charges including second degree murder after one of the largest hepatitis C outbreaks in US history was traced to his clinics.

Investigators at the Centers for Disease Control and Prevention determined that nine people contracted the virus at two clinics operated by Dr Desai, while the infections of a further 105 people may have been related to the clinics.

At least two patients, both men in their seventies, have died as a result of complications from their infections, which were put down to a miserly work environment, including at the Endoscopy Clinic of South Nevada, which encouraged unsafe practices that spread the virus.

Health authorities contacted 63,000 former patients of the clinics to get tested for potentially fatal blood-borne diseases including hepatitis C and HIV clinic after the 2007 outbreak revealed the high risk of cross-infection.

Dr Desai could face additional charges related to the death in August of a second former, and the sentencing judge set an 18-year non-parole period.

Adrian Rollins

TO COMMENT CLICK HERE

No butts as 'toxic tush' doctor ends up behind bars

A backyard operator posing as a medical practitioner has been jailed in the United States after performing procedures that left one person dead and others grossly disfigured.

In what has become known as the case of the "toxic tush", the *Miami Herald* reported that Oneal Ron Morris, 32, appeared in a Miami Court last month to accept a plea deal for one count of illegal practice of healthcare, and will spend 366 days in prison.

The case drew international attention after it was claimed that Morris had injected a mix of toxic substances including Super Glue, tyre sealant, mineral oil and cement into the buttocks of a patient, leaving her struggling in hospital with pneumonia and grossly deformed hips.

Prosecutors said they were unable to determine exactly what substances Morris had injected into her patients, and she may yet face a manslaughter charge arising from the death of a client in a county north of Miami.

The case has shone a light on an underground business in Florida involving supposed doctors performing cosmetic procedures on patients in private homes and hotel rooms, with concerns that dozens of people have been left maimed or disfigured.

Adrian Rollins

TO COMMENT CLICK HERE

Members' Forum

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

Rumours abound regarding what the Abbott Government intends to do with Medicare Locals. In the 21 October edition of *Australian Medicine*, public health expert Stephen Leeder argued dumping the network was a bad idea. One member suggests that, regardless of what happens to Medicare Locals, health services for the Aboriginal community should be funded and controlled by that community.

If they want to keep Medicare Locals for mainstream [health care], that's their business. All Aboriginal health funding needs to go to Aboriginal community-controlled health services. It is blatantly clear that Aboriginal community-controlled health services deliver a better health service to our own mob than any other service provider in this country. Where there are no Aboriginal community-controlled health services, then they need to be established with the support of their State affiliates and that great Aboriginal community-controlled organisation, NACCHO [National Aboriginal Controlled Community Health Organisation]. If we want to close the gap on Aboriginal health the answer is simple: today we have 150 Aboriginal community-controlled health services in this country; the target by 2030 needs to be 300.

Submitted by Sandy Davies (not verified)

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. Some AMA members voice their opinion on the PCEHR system.

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Members' Forum

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

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"patients and privacy activists had won out over doctors in the tug of war over who would control the health record... 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."

The health summary isn't the issue. Just because the summary is the only part of the record that is currently functional, it doesn't mean that this will remain the case - the original plan for the PCEHR was to have a more comprehensive repository of health information. It is the control of the other documents which will be held in the record once it becomes fully functional which is worrying. Concern about patients' ability to change the record is not a "myth or misconception". The legislation that underpins the PCEHR specifically gives control to patients as to what documents are included within the record - documents (investigation reports, prescriptions, correspondence from specialists) may be removed without any tracking whatsoever. This is a particular concern when it comes to medications, particularly any medications that have abuse potential. It becomes too easy for untrustworthy people to manipulate the information within the record to support the outcome that they are seeking - i.e. getting a prescription for a drug of dependence. If the information cannot be trusted to be complete, then it cannot be used reliably to make clinical decisions. Considering the increasing harms that arise related to prescription medication misuse (see some of the coroner's reports from Vic and NSW this year), I find it concerning that the medical folk involved in the process don't recognise this issue at all.

Submitted by Tracy Soh (not verified)

The most important thing for the PCEHR to be useful, is for it to be downloadable in an XML or a database format so that it can integrated into our EHR's on our desks. I cannot believe that so much money has been spent on such a dog of a system.

Submitted by Peter C. Stephenson (not verified)

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

I am assuming the AMA schedule of fees will increase as usual? The rule with the AHSA group of funds is that the known gap for procedures in hospital cannot exceed the AMA fees but the maximum gap is $400.00 with these funds. As the CMBS is not going to increase on 1 November, this means that the maximum gap, when added to the CMBS, will mean the doctor's expected fee will be eroded. All proceduralists who used the Gap cover scheme and the Known Gap fee will be losing, especially for those patients where the doctor uses Gap cover alone (with elderly patients, or for compassionate reasons), as the funds link their annual fee increases to the CMBS, and this is not going to change. Are the funds going to follow the previous government's freezing of the rebate? Please let doctors know soon as we need to work out what policy we will adopt from 1 November, i.e. abandon Gapcover completely perhaps, and set our own fees.

Submitted by Libby Boshell (not verified)

[AMA notes: The AMA indexed its fees on 1 November as usual. The AMA wrote to every health insurer seeking advice on the timing of their indexation. While we have not received responses from all of them, the responses so far have been varied: some are indexing on 1 November as usual; some are partially indexing on 1 November and again in July 2014; some are not indexing until July 2014; and some do not index annually because they pay a percentage of the MBS fee.

The AMA recognises that if private health insurers index their schedules in November as business as usual, they will be incurring some of the Government's savings. The AMA applauds those private health insurers that have decided to index their schedules in November to minimise the impact on their members. Those insurers that delay their indexation will avoid carrying the Government's savings, but will also benefit from a reduction in the growth of their outlays on medical benefits.

As you would no doubt do every year, the AMA advises members to check the insurers' benefits schedules to decide if you will continue to participate in no gap arrangements and known gap arrangements.]

A current medical student describes their first-hand account of what it is like to have a serious mental health condition while studying medicine. One member expresses her thoughts on this story.

You are not alone. I have worked for 30 years with several generations of doctors. Some who were coping well, and others who were yet to be diagnosed. I, too, did some amazing study during my first manic phase. As a postgraduate I shared my story, with a very mixed reception. I, too, was away from work for two years, most of my colleagues learned to let me cry quietly somewhere once a day. We are, as health providers, getting closer to a better understanding of mental health. But as a student, I would still be keeping your fortunate recovery a family and close friend affair.

Submitted by Gaye (not verified)

TO COMMENT CLICK HERE

BOOK REVIEW

The 100 Best Albums of All Time

By Toby Creswell and Craig Mathieson

Hardie Grant, RRP $49.95, ISBN 9781742703015, pp256

Reviewed by John Flannery, Manager, AMA Public Affairs

The Vinyl Countdown

Putting together a list of the best albums of all time is a big ask and a big task. It is also guaranteed to spark argument and debate among rock music lovers of all ages. And that is probably reason enough to do it.

Who better to craft this colossal 'mix tape' of classic hits than veteran music writers, Toby Creswell and Craig Mathieson? Creswell is a former *Rolling Stone* editor, and both did time editing another iconic music magazine, *Juice*. They have both written books about music and musicians.

To make the job easier, they limited the genres to "rock and roll and its near neighbours", while "all time" means something like the last 50 years, and legendary performers like The Beatles and Bob Dylan were only allowed limited entries in the top 100. As it turns out, The Beatles have three and Dylan has two. The only others with multiple entries are Bruce Springsteen (two) and The Rolling Stones (two). Beatles members, John Lennon and George Harrison, also have a solo entry apiece – Harrison with *All Things Must Pass* (48) and Lennon with *John Lennon/Plastic Ono Band* (20).

The beauty of this book is that the albums are not necessarily the ones you would expect to be in the list for various artists. This is certainly true for The Beatles. Sgt Pepper's does not get a mention, with the Fab Four making the cut with *Revolver* (2), *The White Album* (18), *and Abbey Road* (45).

Bob Dylan grabs Number One spot in this fascinating collection with *Highway 61 Revisited*. His other entry is *Blonde on Blonde* (23).

Springsteen scores with *Darkness on the Edge of Town* (12) and *Born to Run* (44), which is probably not the order with which these albums are rated by diehard fans of the Boss. The Stones make the cut with *Sticky Fingers* (7) and *Exile on Main St* (40). No *Born in the USA* or *Let it Bleed* in this collection.

That leaves 89 spots for other artists, and what a wonderful and diverse array of albums from across generations and genres – everything from Chuck Berry, Little Richard, and Aretha Franklin to Devo, Kraftwerk, and Gang of Four.

The allure of this collection is that it is all about the album. Not a couple of catchy singles with a load of filler. It is all about the 'album'. That is why it is full of surprises. And absolute delights. These albums are full of songs that hang together on a theme or a style, or they mark an era, a milestone, or a turning point in rock and roll.

You get the expected – Van Morrison with *Astral Weeks* (5), the Beach Boys' *Pet Sounds* (11), Pink Floyd and *Dark Side of the Moon* (51), and David Bowie's *Hunky Dory* (33).

You get the unexpected – the Monkees with *Headquarters* (56) and *Crooked Rain* (79) by Stephen Malkmus's enigmatic '90s band, Pavement.

Then there are pleasant surprises like the Joni Mitchell classic, *Blue* (6) - the only female artist to make the top 10 – and sublime choices such as Patti Smith's *Horses* (41), *Nevermind* (4) by Nirvana, and Neil Young with *On the Beach* (28). No sign of *Harvest* or *After the Gold Rush*, which will surprise many.

Rap gets a mention, with Public Enemy making it into the top 10 with *It Takes A Nation of Millions to Hold Us Back* (10) and Eminem with *The Marshall Mathers LP* (61). There is jazz with Miles Davis and *Kind of Blue* (42), reggae with *Burnin'* (55) by The Wailers, and the Sex Pistols lead a surprisingly strong punk charge with *Never Mind the Bollocks* (24).

From a personal perspective, I am delighted that Joy Division, the Modern Lovers, the Pixies, the Smiths, Talking Heads and Television all have albums in this list.

Rock purists will love the fact that Black Sabbath, Led Zeppelin, The Doors, and Queen are there, too.

Folkies can take heart that Fairport Convention are recognised, and Australia is represented by AC/DC and Midnight Oil.

The writers lovingly describe the stories behind these albums and their reasons for including them in the Top 100. It is clear they hold strong affection for the album as an art form – the embodiment of rock and roll.

Underneath it all, though, is more than a hint of nostalgia – for vinyl records, record stores, and cult music magazines – and a yearning for an era when there was 'real music' and rock and roll 'gods'.

This is a great book for music memories … and starting fights.

TO COMMENT CLICK HERE

The Prince of Pinots - Grant Taylor

BY **DR MICHAEL RYAN**

Grant Taylor is a visionary. From humble viticultural beginnings, Grant has forged a name for himself as one of the greatest Pinot Noir makers in the world. He is the only person to be coveted with the award as World's best Pinot Noir maker three times at the London International Wine Fair. Perhaps his Italian heritage (his great-grandfather was Giuseppe Valli), which meant he grew up immersed in the intricacies of food and grape growing, is to be thanked.

He is a humble man with a vision to make a Pinot Noir that represents the terroir it comes from. It's a goal of his to have Central Otago Pinot Noir known as a distinctive style, similar to the appellation of French houses of Burgundy.

He has been based in the Central Otago region of New Zealand for 30 years, and has wines from the Gibbston Valley, the Bannockburn region, Bendigo and the Waitaki region in North Otago, which is a new wine region. He makes Riesling from grapes from the Alexandra region.

He swims against the tide. In his Gibbston Valley vineyard, the trellises run north-south, while everyone else in the Valley plants them east-west. He was the original wine maker at the Gibbston Valley winery, and has done vintages in Oregon.

Waitaki holds a special place for him as it is his birthplace. This maritime-influenced region of North Otago is producing elegant wines. The limestone and alluvial soils make for arduous work from the vine, but the slow ripening period sees fruit hanging through til late April and early May. Fruit and acid characteristics abound.

I first met Grant in New Zealand four years ago. A pure delight. Recently, I hosted a dinner with his Marketing Manager Hollis Giddens. This well-versed, immaculately dressed wine siren is an asset to the Valli Team. The Mississippi twang is a delight to listen to.

The wines shone bright, educating the guest about the fascinating world of terroir. While the room polarised on which was the favourite, all agreed that they are exquisite wines made with attitude, elegance and sense of place. The restaurant, Harrys of Buderim, provided five courses of sensational food.

WINES TASTED

1. 2012 Valli Alexandra Riesling

Light straw colours with hints of green. The nose has delicate lime citrus notes, with some floral and minerality. The palate delights with anterior, tightly wound fruit flavours that develop as the wine warms up. Acidity is wonderfully rampant, with almost no residual sugar. Cellar for six years. Had with chilled leek and Ceas spanner crab soup.

2. 2011 Valli Waitaki Pinot Noir

Attractive dusky red colours. The bouquet exudes red, well-ripened fruits. Brambly nuances flitter with some oak characteristics. The palate at first feels overripe, but within 10 minutes it morphs into a complex, integrated wine. Cellar for 10 years. Drank with fried sheep's cheese fennel salad.

3. 2011 Valli Gibbston Valley Pinot Noir

A brighter red colour. The aromas of delicate red fruits and cherries are typical of the region. Twiggy, funky spicy aromas develop. The palate is silky, but then develops a peak of acid and structure. Cellar 10 years. Drank with Hervey Bay scallops and pork belly on mustard mash.

4. 2011 Valli Bannockburn Pinot Noir

Deep red to purple. Big, complex, red to plummy fruits delight. Hints of Asian spice, tarragon and even leathery notes appear. Somewhat typical of the big Pinot Noir of Central Otago, but balanced by Grant Taylor's ability to produce the 'iron fist in a velvet glove'. The palate is sweeping with fruit structure and desirability. Cellar 12 years. Drank with Caramelised duck a la orange.

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