AUSTRALIAN
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CPD TRACKER

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Videoconferencing: the time has come

BY **AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB**

The AMA has recognised the role that modern technology can play in providing an adjunct to face-to-face consultations.

Within the AMA List of Medical Services and Fees, November 2013, are a number of video consultation and telehealth items that can enhance patient care. At the moment, many of these services are a step ahead of the items included in the Medicare Benefits Schedule for patient rebates.

Nevertheless, these technologies are developing rapidly, and it can only be a matter of time before the benefits of using modern technology to provide some services to patients in this way are fully recognised.

When interacting with country health services in Western Australia, I have been fortunate to observe first hand the value of video consultations, as well as the use of videoconferencing for meetings or to improve the frequency of communication with health consumer groups.

Commonwealth Government agencies such as the Independent Hospital Pricing Authority have been making extensive use of videoconferencing as a meeting format. As a participant in these meetings, I can say that the technology has generally worked well. In particular, my experience has been that it is a considerable advance on telephone conferencing, especially for larger groups.

The AMA's business has traditionally been conducted through face-to-face meetings using a committee format, although some of our committees, such as Finance and the Council of Salaried Doctors, have conducted much of their business by teleconference.

During the past year, the Public Health Committee has conducted business by a combination of face-to-face meetings, teleconferences and email exchanges to finalise Position Statements. The Therapeutics Committee has conducted business by teleconference and email exchange.

Face-to-face meetings provide collegial interaction and the opportunity for informal interactions during meeting breaks. Members benefit from both verbal and visual communication, and it is easy to share documents in hard copy or have them displayed on a screen.

However, face-to-face meetings incur costs for travel, accommodation and venue hire, all significant parts of the AMA's expenditure. The costs also mean the meetings are relatively infrequent and usually occupy a whole day or weekend.

Being able to commit to such long meetings, especially when they are held interstate, may inhibit significant parts of the profession from participating in Federal AMA activities, particularly when there are considerable family commitments.

The AMA needs to recognise these barriers to member participation, particularly in policy development, where member voices needs to be heard, and find ways by which they can be overcome.

Teleconferences work well for procedural matters with a well defined agenda that includes mainly issues for information or decision, especially when the group on the teleconference knows each other well and is not too large.

They are, however, subject to problems with maintaining connections, they only allow verbal communication, and it can be difficult to share documents in real time.

The technology associated with videoconferencing has been improving. It has the potential to provide better interaction and document sharing than teleconferences, and are of lower cost than face-to-face meetings.

While there is a set up cost for hardware and software, the reality is that most members will have the computing capacity and internet connections needed in their practices and at home.

At a time when there is an increasing need to be more agile and responsive in the face of expectations that organisations will provide submissions to Government proposals within ever-shorter deadlines, the AMA needs to adapt to the environment in which we work. Videoconferencing could allow more frequent and shorter meetings, enhancing the AMA's responsiveness but without the time commitment involved in travelling to face-to-face meetings.

It is noticeable that the AMA's the processes for public policy development have been gradually changing over time, with greater use of email input from the members of Federal Council and its Committees and Councils, and the use of smaller, time-limited working groups to develop draft Position Statements.

Videoconferencing is another tool that we can use. It is not a complete substitute for face-to-face meetings, but it potentially means these will have to be less frequent, reducing the time commitment required for members to participate, and providing a means to accelerate the process of policy development between face-to-face meetings.

Trials of videoconferencing are currently underway within the Secretariat after an examination of the many videoconferencing options that are now available.

These trials use a system that allows participants to join a videoconference from their own computer once it has the relevant software and is equipped with a suitable camera and speakers.

I anticipate that a measured rollout will then occur, with videoconferencing increasingly used by committees as an improvement on teleconferences.

It's a technology whose time has come, whether that be for patient care or our work for the AMA.

TO COMMENT CLICK HERE

Health and ageing responsibilities spread wide in Abbott Government

BY AMA SECRETARY GENERAL ANNE TRIMMER

"An ongoing concern has been the need for a review of the PCEHR to make it more clinically relevant to medical practitioners"

Last week saw the return of Federal Parliament for the first sittings since the election was called in August.

It has been a quiet start for the new government, with limited announcements and minimal media activity, as it has gone about establishing Ministerial offices and appointing staff. The tone and activity levels in Parliament House are very different from the past – and that is just the way Prime Minister Tony Abbott wants it.

AMA President Dr Steve Hambleton and I met with Health Minister Peter Dutton soon after his appointment as Minister. Mr Dutton has a strong grasp of health policy issues, having shadowed the portfolio in Opposition during the past six years. He is also in the unusual position of having a Prime Minister who is a previous Minister for Health, and who continues to have a strong interest in health policy.

We had several issues on our agenda for the meeting, including the planned Medicare Local review, which the Minister confirmed would have similar terms of reference to those announced prior to the election, and which align closely with the areas for review proposed by the AMA Council of General Practice. The review is yet to be formally announced.

We raised concerns about the medical workforce training pipeline, particularly bottlenecks beyond postgraduate year 1. It was pleasing to see that the National Medical Training Advisory Network proposed by Health Workforce Australia was agreed to by the Standing Committee on Health last week – a big step forward. For the first time there will be a coordinated medical training system with five-year rolling medical training plans.

An ongoing concern has been the need for a review of the PCEHR to make it more clinically relevant to medical practitioners. Subsequent to our meeting, the Minister announced the establishment of a small panel (which includes Dr Hambleton) to undertake a short and focused review with a tight reporting timeline.

Another issue on our agenda was examination of the PBS Authority system, which imposes significant red tape on GPs – adding unnecessary wasted time in a busy day as they wait for authority to prescribe certain medications. The Minister has agreed to review the current arrangements to see if they can be further streamlined.

Dr Hambleton and I have had the opportunity for an informal meeting with Minister Fiona Nash, who has diverse portfolio responsibility as the Assistant Minister for Health. Senator Nash takes on the areas of rural and regional health, public health issues such alcohol, tobacco and food, the delivery of Indigenous health, and the Therapeutic Goods Administration.

Parts of the old Health and Ageing portfolio have now been redistributed far and wide - Indigenous health policy now resides with the Department of Prime Minister and Cabinet, while policies on ageing and delivery of services for the ageing now fall within the ambit of the Department of Human Services, and Assistant Minister for Social Services Senator Mitch Fifield.

Co-ordination of advocacy across multiple departments will be an interesting challenge under the new government.

The newly-appointed Shadow Minister for Health, Catherine King, has had some prior exposure to health policies as Parliamentary Secretary for Health in the Rudd and Gillard governments.

With the commencement of the Parliamentary term, the AMA looks forward to engagement with the new Government and Opposition.

There is never a shortage of health policy issues to be raised with our political leaders.

TO COMMENT CLICK HERE

Scrap the Tax - Special Feature

'Flawed' tax cap dumped

The AMA and its members have won their battle to have the $2000 cap on tax deductions for work-related self-education expenses dumped.

In an outcome hailed by AMA President Dr Steve Hambleton as a "victory for common sense", the Abbott Government earlier this month announced that the tax cap, which was due to come into effect in mid-2015, had been scrapped.

The decision was the culmination of months of lobbying by the AMA and a range of other industry groups and professional organisations, and has been met with relief by thousands of doctors who faced being left, on average, $10,000 out of pocket if the cap came into effect.

Dr Hambleton said the cap was a tax on learning that would have threatened the quality of health care by discouraging doctors from undertaking the continuing education and training needed to keep abreast of the latest developments in medical treatment.

He said it would have had a similarly devastating affect across the professions, where ongoing professional development was vital to sustaining high quality service standards, and would also have hit the education and hospitality sectors hard.

Former Treasurer Wayne Swan announced the cap in April as part of a package of tax measures intended to help fund reform of school education, and justified it as a legitimate crack down on inflated tax claims for extravagant conferences and workshops involving first class air fares and luxury hotels.

But almost from the moment it was unveiled, the AMA was at the forefront of efforts to have the measure repealed, warning that it would cripple professional development and potentially undermine the standard of care.

"You dumb down the country by stopping people self-educating and improving themselves, in whatever field they are in," Dr Hambleton said. "The proposed cap was a poor policy that would have undermined medical education and training and made it increasingly difficult for doctors to provide quality health care."

The AMA President said the incoming Coalition Government had "clearly" heeded the medical profession's warnings: "We asked the Government to scrap the cap, and they have delivered."

Treasurer Joe Hockey said the cap was an ill-conceived policy that undermined efforts to boost the nation's productivity.

...CONTINUED ON PAGE 6

Tax cap dumped: the reaction

The $2000 tax cap galvanised the medical profession like no other issue since the medical indemnity crisis of the early 2000s.

When the Abbott Government announced on 6 November that the cap was dead, the AMA – which has led the fight against the change – was deluged with messages of congratulation and relief from its members. Here is a selection:

Good news!

Congratulations and thank you for the convincing effort you and AMA have put into the campaign.

Kind Regards

John Saalfeld

This is fantastic news.

Thank you for your hard work.

Kind Regards,

Matthew Hauser

Well done. Common sense at last!

Glenda Powell

Good news Steve [Hambleton].

A job well done.

My thanks to all at the AMA for standing up for common sense.

Keep up with the good work you are doing.

Laurie Stevenson
Radiologist

Congratulations

Poor policy is finally seen for what it is.

Fraser Brown

Brilliant work, so very sensible.

Well done

Marilyn Rochefort

Well done AMA!

Dr Winsome Hum
Consultant Psychiatrist, Monash Health

Thank you all very much for this.

This was just unbelievable,

Dr V Prasad

Thank you and the AMA for your strong efforts with this, and for promptly informing me.

Dr Sam Giummarra

Dear AMA President

Well done. Thank you so much

Regards

Michael Khalil

ScraptheTax - Special Feature

'Flawed' tax cap dumped

...CONTINUED FROM PAGE 5

Announcing that the cap had been scrapped, Mr Hockey said that of the 639,000 taxpayers who claimed tax deductions for self-education expenses, less than a third (174,000) made claims in excess of $2000.

And of those 174,000, 81 per cent earned less than $80,000 a year, he added.

"They are the people who are trying to invest in their own education to get ahead," Mr Hockey said. "It was flawed policy, with no motivation other than a simple headline.

"The [Labor] Government recognised that when, between the course of the Budget and the election campaign, they announced a delay.

"They would never have done it, because they would have been clubbed by the reality that people should be investing in their own education. That is how we improve productivity."

Dr Hambleton praised the Abbott Government for heeding the AMA's warnings about the potentially devastating effects of the tax cap.

"The AMA was probably the first group to come out to actually recognise the impact of this," the AMA President said. "It was going to have a huge impact on junior doctors, a huge impact on rural doctors, and a huge impact on the medical profession's ability to stay up to date.

"We congratulate the Government for actually understanding, hearing the message, and delivering an outcome which is quite appropriate for the medical care of Australians.

"This means Australian doctors will be able to stay up to date, they'll be able to maintain their position as first-world care in this country, maintain the self-education, look after the people of Australia."

Dr Hambleton also paid tribute to the thousands of AMA members who took part in the campaign to have the cap abolished, including writing to their local MPs, participating in surveys, signing petitions and sharing their stories, including through the doctors4health and scrap the cap campaign websites.

"For AMA members, this victory has probably paid for their AMA subscription for the rest of their lives," he said. "It is one of the most tangible reasons for non-members to pay their subscriptions so that the AMA has got the resources to take up similar issues in the future."

Adrian Rollins

TO COMMENT CLICK HERE

Tax cap dumped: the reaction

Dear Dr Hambleton,

Thank you for the email and the good news.

Thanks to AMA for the efforts made in bringing about this change in policy.

Regards,

Dr Devi Radhakrishnan
Medical Registrar, RPH

Dear Mr Hambleton

On behalf of the Victorian Medical Women's Society, I wish to thank you for your effort on this matter.

As medical women, we feel that it would have made it even harder for us to be able to afford some very necessary further education, due to cost and our reduced income, due to the fact that we often have families and work shorter sessions.

Yours sincerely,

Magdalena Simonis

President

Victorian Medical Women's Society

Dear Dr Hambleton,

Thank you for informing me about this. I am pleased to hear that the AMA has been successful in their pressure.

I was not very surprised though, taking into account the fact that weddings, sports events, inspections of investment properties and footy games are apparently tax-deductible and/or claimable in the current political climate.

Yours Sincerely,

Bertel Bulten

Yay!

Thanks AMA

Dr Ian Gotis-Graham and Dr Christina Gatzastras

Dear Dr.Steve,

I am extremely delighted with this news and would like to thank AMA whole heartedly for all their support in achieving this for all us doctors.

With Kind Regards,

Dr Gayatri J. Borude

Consultant in Reproductive Medicine , Obstetrics and Gynecology.

Thank you, congratulations and appropriately well fought

Regards

Dr Murray Blythe

Southern Cross Orthopaedic Group

Well done, great result.

Timothy J G Pavy

Head, Department of Anaesthesia and Pain Medicine

King Edward Memorial Hospital for Women

ScraptheTax - Special Feature

How the cap was scrapped

When former Treasurer Wayne Swan used a quiet Saturday in April to announce a $2000 cap on tax deductions for self-education expenses, AMA President Dr Steve Hambleton immediately knew this would be bad for doctors.

A practising GP himself, he was well aware how much it cost to keep up with the latest developments in medicines and medical treatment, and saw that the $2000 cap would put most of the medical profession – particularly rural doctors and those in training – deeply out of pocket, as well as undermining the continuing professional development crucial to maintaining the nation's high quality of health care.

Within hours of the announcement, senior AMA officials were in discussions about how to convince the Labor Government to ditch the ill-informed tax change.

On the morning of 16 April, less than 72 hours after Wayne Swan's press conference, the AMA officially got its anti-tax cap campaign underway, issuing a media statement condemning the move and formally approaching the Treasurer's office to seek an urgent meeting on the issue.

The following day the AMA's Executive Council gathered in Canberra to plan their strategy, and Dr Hambleton called both Health Minister Tanya Plibersek and his Opposition counterpart Peter Dutton to detail concerns with the tax change and argue for its repeal.

By the end of the week, AMA officials had already held their first meeting with the Treasurer's advisors, and plans were well advanced for a survey of AMA members to gauge the likely effect of the tax cap.

What followed was weeks and months of increasingly intensive lobbying and campaigning, both in the full glare of public scrutiny and behind closed doors, to convince all sides of politics the tax cap was a bad idea, not just because of it would hurt doctors, but because of its chilling effect on ongoing education and training across the professions.

As Dr Hambleton was to argue repeatedly over the coming months, it was a "doubly-dumb" impost that deterred people from enhancing their skills and knowledge and directly undermined efforts to enhance national productivity and competitiveness.

On 1 May the AMA announced the results of its initial survey. An extraordinary 4581 members responded, and of these 98 per cent declared the cap would impair their professional development.

Federal AMA, in conjunction with AMA (NSW), developed the doctors4health website as a forum for members to share concerns about the likely effect of the cap, and to provide information to doctors on how to begin lobbying their local MPs.

...CONTINUED ON PAGE 8

Tax cap dumped: the reaction

Dear President

Congratulations to you and the whole of the AMA.

This is a great victory for common sense and perseverance.

Dr Thomas Hardy

Melbourne (in Hobart on conference!)

Thank you Steve this is indeed very good news.

It is extremely important now that we as a profession do not leave ourselves vulnerable to accusations of rorting this deduction into the future.

If we are not seen to use this privilege ethically and responsibly we will surely loose it sooner or later and deservedly so.

Best wishes

Dr Rod Brown

Dear Dr Hambleton

This is indeed good news, and a just result for the sterling efforts of you and your colleagues.

I wrote a strong endorsement for the AMA's stance in my column in *The Australian Doctor*, and am gratified to see the case for reason articulated by our profession to be acknowledged by our new Government.

My thanks and congratulations.

Yours sincerely

Dr Christopher Swan

Fantastic news!

Thanks to AMA for all your hard work coordinating our responses.

Regards,

Dr Ruth-Ellen Marks

Fantastic result, for doctors and many other professionals & technicians!

Barb Bauert

Congratulations to the AMA, and thank you for your hard work on this issue.

Next challenge - individual contracts in Queensland HHS boards... this will be tougher, and we really need your help.

Associate Professor Christian Hamilton-Craig

Staff Cardiologist, The Prince Charles Hospital, Brisbane

ScraptheTax - Special Feature

How the cap was scrapped

...CONTINUED FROM PAGE 7

Both Ms Plibersek and Mr Dutton were grilled on the tax cap when they attended the AMA National Conference on 24 May, and the following day the Conference unanimously passed a motion condemning the tax change.

By this stage the AMA had contacted other professional organisations and industry groups, building awareness that this was not just an issue for the health sector, and at a meeting on 3 June Dr Hambleton and Universities Australia Chief Executive Officer Belinda Robinson agreed to bring together those with an interest in seeing the policy overturned.

On 21 June the Scrap the Cap website (a slogan coined by AMA Director of Public Affairs John Flannery) went live, and on 8 July the first meeting of the Scrap the Cap Alliance – bringing together representatives from 22 peak industry groups and professional organisations – was held.

The following week the AMA delivered its response to a Treasury Discussion Paper on the cap, in which it criticised the poor quality of argument and analysis used by the Government's chief economic agency to justify the impost.

Expert analysis by Cutcher & Neale Accounting and Financial Services highlighted significant ambiguities and concerns in the way the tax change would operate in practice, including regarding fringe benefit tax liabilities.

On 17 July Dr Hambleton made sure arguments against the tax reached a national audience when he raised the issue during his annual address to the National Press Club.

On 25 July the first crack in bipartisan acceptance of the tax change appeared when, following as meeting in Adelaide with Dr Hambleton and other representatives of the Scrap the Cap Alliance, Shadow Education Minister Christopher Pyne came out and strongly opposed tax change, condemning it as "bad policy".

The AMA kept the story in the headlines four days later when it released the results of a second, more detailed survey based on responses from 4200 doctors, which showed just how debilitating the tax cap would be for professional education.

The survey found that they spent, on average, $12,637 a year on self-education expenses (one trainee doctor itemised expenses totalling $40,000), meaning the cap would leave them $10,000 out-of-pocket if they maintained their commitment to training and education.

On 30 July the AMA hosted the second meeting of the Scrap the Cap Alliance, which had swelled to include 75 organisations and industry groups, including universities, engineers, dentists, veterinarians, hospitality and tourism industry representatives, and arhcitects.

Armed with evidence of how corrosive the cap would be for professional education, and backed by a strong swell of support across the professions and industry, Dr Hambleton and senior AMA official on 31 July met with then-Opposition Leader Tony Abbott and Mr Dutton to drive home the need to ditch the cap.

...CONTINUED ON PAGE 9

Scrap the Cap timeline

13 APRIL – Treasurer Wayne Swan announces a $2000 cap on tax deductions for work-related self-education expenses, to come into effect from 1 July 2014. Expected to save $514.3 million over four years

16 APRIL – AMA issues press release announcing its opposition to the tax change

- AMA President Dr Steve Hambleton writes to Mr Swan raising concerns about the cap and asking for meeting

17 APRIL – Dr Hambleton calls Health Minister Tanya Plibersek to object to the measure and calls Shadow Health Minister Peter Dutton to discuss the issue

- AMA Executive Council meets to discuss tax cap campaign

19 APRIL – Senior AMA officials meet with senior adviser to Treasurer

22 APRIL – AMA begins first survey of members on proposed tax cap

24 APRIL – AMA writes to all Federal MPs setting out objections to tax cap

1 MAY – Dr Hambleton meets with Department of Health and Ageing Secretary Jane Halton

- AMA releases initial results of online poll: of 4581 responses, 98 per cent of doctors report it will impair their professional development

EARLY MAY – Federal AMA, in conjunction with AMA (NSW) sets up the doctors4health campaign website

24 MAY – Ms Plibersek and Mr Dutton grilled on tax cap when they attend AMA National Conference, Sydney

25 MAY – AMA National Conference unanimously passes motion demanding Federal Government "urgently reverse" tax cap decision

31 MAY – Tax cap Discussion Paper released by Treasury

ScraptheTax - Special Feature

How the cap was scrapped

...CONTINUED FROM PAGE 8

The first sign that the relentless campaign was wearing down the Labor Government came two days later when Mr Swan announced the introduction of the cap would be deferred a year, until 1 July 2015.

During the Federal election campaign the AMA and the Alliance worked to keep the cap alive as a campaign issue, though Dr Hambleton admitted later that the Coalition was probably not in a position to commit to scrapping the cap unless or until it was elected and could assess the health of the Commonwealth's finances.

As they campaigned for the cap's abolition, a major fear for Dr Hambleton and senior AMA officials was that, instead of scrapping it, the next Government would opt to simply raise the $2000 cap – a move that could have whittled down opposition to the tax change and left the medical profession increasingly isolated in its objections.

Early this month, as they were preparing to meet with Shadow Treasurer Chris Bowen as part of steps to reinvigorate the anti-cap campaign, Dr Hambleton, AMA Secretary General Anne Trimmer and AMA senior policy officer Warwick Hough travelled to Sydney for a meeting with Assistant Treasurer Arthur Sinodinos.

At the 6 November meeting, Senator Sinodinos assured the AMA officials that he understood their concerns about the tax cap, noted the strong representations made by Mr Pyne against the measure and said Treasurer Joe Hockey had looked very carefully at the issue.

He told them Mr Hockey was about to make a statement on tax measures that they should watch very carefully.

The following day, the Treasurer announced the tax cap was among seven tax measures inherited from the Labor Government that had been dumped.

It was a successful conclusion to a campaign that Dr Hambleton said had galvanised the profession like few others.

"This issue has created more feedback and more support and more rallying of the troops for the AMA than any single issue since the medical indemnity crisis," the AMA President said. "It created common ground from the most senior specialist to the most junior intern; metro and rural; all were affected."

He said the full gamut of campaign tactics were used, from personal meetings and petitions to individual MPs, to media events and extensive use of social media, including the creation of a Facebook page that received more than 50,000 likes, and more than 24,300 signatures on the Scrap the Cap online petition.

"This is all about what the AMA does well," Dr Hambleton said. "We got early feedback about the seriousness of the tax change, we wrote to every politician, we refined and updated the message, we maintained momentum, and we got the result."

Adrian Rollins

TO COMMENT CLICK HERE

Scrap the Cap timeline

3 JUNE – Dr Hambleton and Universities Australia chief executive Belinda Robinson agree to bring together key stakeholders affected adversely by the tax cap

21 JUNE – Scrap the Cap website (slogan developed by AMA Public Affairs manager John Flannery) goes live

8 JULY – first meeting of the Scrap the Cap Alliance is held at Universities Australia, attended by representatives from 22 peak industry and professional organisations

17 JULY – In speech to National Press Club, Dr Hambleton highlights widespread concern over the tax cap

18 JULY – AMA lodges tax cap submission with Treasury

25 JULY – Shadow Education Minister Christopher Pyne condemns the tax cap as "bad policy" following a meeting with Dr Hambleton and other members of the Scrap the Cap Alliance

29 JULY – AMA publishes results of a major survey of 4200 doctors, showing they spend on average $12,637 a year on self-education expenses, meaning the cap will leave them $10,000 out of pocket

30 JULY – AMA hosts meeting of representatives from 30 organisations that are part of expanded 75-member Scrap the Cap Alliance

31 JULY – Dr Hambleton and senior AMA officials meet with Mr Abbott and Mr Dutton to urge the tax change be ditched

2 AUGUST – Treasurer Wayne Swan announces deferral of tax cap to 1 July 2015

7 SEPTEMBER – Coalition wins Federal election

5 NOVEMBER – Dr Hambleton and AMA Secretary General Anne Trimmer meet with Assistant Treasurer Senator Arthur Sinodinos to discuss the cap

6 NOVEMBER – Treasurer Joe Hockey and Senator Sinodinos announce the cap has been scrapped

AMA at centre of PCEHR overhaul

The AMA has been given a central role in overhauling the troubled shared electronic health record scheme after President Dr Steve Hambleton was appointed by the Abbott Government to a three-member review panel.

Health Minister Peter Dutton has selected Dr Hambleton, along with UnitingCare Health Executive Director Richard Royle and Australia Post Chief Information Officer Andrew Walduck, to undertake a six-week assessment of the $1 billion Personally Controlled Electronic Health Record (PCEHR) system, which has so far failed to attract much interest from the medical profession or patients.

Mr Dutton said the Government embraced the opportunities for better health care offered by electronic health records, but the PCEHR as currently structured fell well short of fulfilling this potential.

"There are only a few hundred doctors that are actually uploading details into people's files, and it has been a scandal," Mr Dutton said on Sky television. "So, on those numbers, it runs out at about $200,000 a patient in terms of the investment the former Government made."

"The Government fully supports the concept of electronic health records, but it must be fit for purpose and cost effective," the Minister added.

Dr Hambleton said the focus of the review was to find ways to improve the PCEHR, not kill it off.

"The intent is to fix it, not to take it out," he said. "The Minister's belief is that this is something we should be salvaging."

On the face of it, the review panel faces a huge task.

While more than one million people have registered for a shared health summary, only a few hundred have been uploaded by a handful of doctors, with most shunning the technology because in its current form they do not see it as useful or of benefit to either them or their patients.

Dr Hambleton admitted that "the goodwill for the original proposal has really evaporated…the profession is very unhappy because they cannot see the benefit".

But he is confident that the PCEHR can be changed and improved in ways that will make it clinically relevant and easy to use for both practitioners and patients.

Dr Hambleton said many people were unaware that most of the essential building blocks for a useful e-health record system were already in place.

"I got off the plane with a top IT expert [last week] and told him is was on a review of the PCEHR and he said 'What's that?' and then said it would require a system of unique health identifiers.

"The fact is, we already have that, as well as a classification system for diseases. A lot of the fundamental work has been done."

Instead, the review has been set a number of tasks aimed at making the PCEHR a system that is useful for doctors and patients alike, and one that they both want to use.

Mr Dutton has asked it to:

- identify gaps between the expectations of users and what has been delivered;
- the extent of consultation with end users; the use of the PCEHR by health care professionals in clinical settings;
- clinician and patient usability issues;
- new functions that would improve its usefulness;
- incentives to boost usage;
- potential integration with comparable private sector products; and
- the future role of the private sector in providing solutions, and the policies that might help encourage this.

Dr Hambleton said he would be guided in the review by the central question for doctors of "how does [the PCEHR] fit into my day. To work, it needs to fit in with the workflow seamlessly, and there must be tangible benefits, not all of which are necessarily financial".

Review Chair Mr Royle told *iTnews* the PCEHR presented an invaluable opportunity to vastly improve the understanding and management of population health.

> "the goodwill for the original proposal has really evaporated…the profession is very unhappy because they cannot see the benefit"

He said data collected through the electronic health record could be aggregated and used to analyse the frequency and spread of disease and examine disparities in health.

"What this would essentially be doing is taking the PCEHR to another level," he told *iTnews*.

Dr Hambleton said the review's tight deadline – it is due to report to the Minister in mid-December – precluded any public hearings.

Instead, the panel has begun to invite submissions from key stakeholders, as well as organisations and individuals who have participated in previous consultations on the scheme.

Dr Hambleton said the AMA would make a submission to the review.

Adrian Rollins

TO COMMENT CLICK HERE

GPs get MRI go-ahead, but not for lower backs

General practitioners can now directly refer adult patients for magnetic resonant imaging of the head, neck and knee after the Federal Government signed off on recommendations from a group of medical experts, but GPs are still being denied the ability to order scans for those with lower back pain.

In a move welcomed by the AMA, Health Minister Peter Dutton announced on 1 November that $75 million had been allocated over two years to enable GPs to directly request Medicare-rebated MRI scans for head, neck and knee complaints in patients older than 16 years, rather than having to refer patients to a specialist first. It follows the introduction a year ago of GP-referred MRI items for patients younger than 16 years.

Mr Dutton said the change meant patients could receive a Medicare rebate for four different types of MRI services without having to go to the cost or inconvenience of seeing a specialist or consultant physician first, and would also reduce potential radiation exposure.

"The availability of these items should help reduce the need for patients to be exposed to radiation which is associated with other types of diagnostic imaging, like computed tomography (CT) scans," the Minister said.

AMA President Dr Steve Hambleton said it was an important decision which would improve patient care and save the health system money.

"[Until now] GPs [have] effectively been denied direct access to the best available technology for their patients," Dr Hambleton said. "These new items will improve access to care, reduce costs to the health system, and provide further support for GPs to provide better care for their patients."

Under the change, GPs can order a head MRI for patients suffering unexplained seizures or chronic headaches with suspected intracranial pathology; a knee MRI for cases of suspected acute tears of the meniscus or anterior cruciate ligament; and spinal MRIs to investigate cases of suspected cervical spine trauma or cervical radiculopathy.

Chair of the AMA Council of General Practice Dr Brian Morton said the new MRI items were a "good first step", but more needed to be done to ensure patients had access to the best available care.

Dr Morton said GPs were still being denied the ability to directly refer patients suffering lower back pain for an MRI, despite it being one of the most common presentations they saw.

He said that while the ability to request MRI scans of the head, knee and neck was useful, the area where it would be of greatest benefit would be in the diagnosis of lower back complaints.

The Health Department has flagged that there will be a review of diagnostic imaging for lower back pain, but the timing and conduct of the inquiry is yet to be announced.

Dr Morton said it was disappointing that the AMA had not been included in the working group advising on GP requested MRI

items for adults, after contributing to deliberations that led to the creation of similar items for children.

Other medical organisations are also worried about the delay in giving GPs the ability to request MRIs for patients with lower back pain.

It is understood that the Royal Australian and New Zealand College of Radiologists has voiced concerns that patients who would benefit from an MRI scan are instead being examined using CT scans, exposing them unnecessarily to extra doses of radiation.

Dr Morton said it appeared the decision to delay GP authority to request MRI scans for patients with lower back pain was due purely to money.

"It is short sighted to attempt to restrict use of a safer and more appropriate imaging modality on the basis of non-clinical (cost) reasoning," he told the Health Department.

"The reality of practice is that referral to a specialist in a particular discipline, in most cases where imaging is required, results in the ordering of an MRI.

"The cost to the patient and Medicare is greater than had the MRI been performed prior to the referral, and that also translates to better access to, and efficiency of, that specialist discipline for which waiting time[s] can be significant."

The Royal Australian College of General Practitioners has developed clinical guidance for GPs considering referring adult patients for an MRI scan.

The guide advises that "GPs should be cautious in the decision to use MRI. Clinical history and physical examination are keys to advising patients about appropriate imaging".

The College said the advice given in the guide was based on the premise that MRI was an "adjunct to patient management, not as a first-line diagnostic tool".

The guide can be viewed at: http://www.racgp.org.au/download/Documents/Guidelines/clinical-guidance-for-mri-referral.pdf

Adrian Rollins

TO COMMENT CLICK HERE

Overseas doctors warned off Queensland public hospitals

"Removing the solution to a patient safety crisis and risking that crisis [returning] defies sanity"

Doctors overseas are being warned to "steer clear" of Queensland after the State Government announced plans to force senior medical staff in public hospitals onto draconian individual contracts.

In a sign that the proposed industrial changes are beginning to hurt Queensland's ability to recruit internationally to fill key vacancies, doctors in New Zealand are being urged reconsider any plans to work in Queensland public hospitals.

This is significant because New Zealand has been an important source of medical specialists to fill shortages in the Queensland health system, particularly in the past six years.

In a strongly-worded statement, the Executive Director of New Zealand's Association of Salaried Medical Specialists, Ian Powell, warned senior doctors to "steer clear of considering employment opportunities in Queensland public hospitals".

"Members who are considering working in Queensland public hospitals are strongly advised to reconsider, especially if the position is more than a short term locum," Mr Powell said. "Please be aware that if you take up a position in a Queensland public hospital you will have fewer rights, fewer protections and less negotiating strength."

Mr Powell made his warning after the AMA condemned the proposed employment contracts as "unfair and unbalanced", and predicted they would cause an exodus of senior specialist staff from the Queensland public hospital system.

AMA President Dr Steve Hambleton said the new contracts, to be introduced from 1 July next year, would strip away key employment rights and protections, including fatigue provisions, rest breaks, limits on hours, and unfair dismissal and dispute resolution 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," Dr Hambleton said.

Mr Powell said the decision by the Queensland Government to introduce such punitive changes to employment conditions for public hospital doctors "defies sanity".

He said that Bundaberg Hospital scandal, in which the deaths of several patients were attributed to poor standards of care, had highlighted the risks of "bad appointments" to fill critical shortages of senior medical staff in public hospitals.

As a result, six years ago, the-then Queensland Government negotiated a collective agreement with salaried doctors to offer substantially improved remuneration and better conditions, which Mr Powell said allowed the State to "dramatically overcome" its recruitment and retention problems.

"Queensland now has a new Government," he said. "Flushed with political power and ideology, it has forgotten history and patient safety.

"The new law would undo the good that was achieved by collective bargaining that overcame Queensland's hospital doctor recruitment and retention crisis that was a major cause of the Bundaberg patient deaths tragedy.

"Removing the solution to a patient safety crisis and risking that crisis [returning] defies sanity." Mr Powell said.

"If there is a return to Queensland's recruitment and retention crisis, then increased patient safety risks would be an unsurprising consequence," he added.

Adrian Rollins

TO COMMENT CLICK HERE

Patient health put at risk by expanded prescribing rights

The health of patients will be put at risk unless the nation's Health Ministers reverse a controversial decision to allow optometrists, nurse practitioners, midwives and other non-medical health professionals to prescribe drugs, the AMA has warned.

The Standing Council on Health, which comprises the Federal, State and Territory Health Ministers, has approved changes allowing non-medical health professionals to prescribe medications without supervision from a medical practitioner.

The meeting on 8 November approved the Health Professionals Prescribing Pathway developed by Health Workforce Australia, which sets out the steps required for a health professional to be authorised to prescribe drugs within their scope of practice.

The Pathway was developed on the assumption that doctor shortages in some areas were making it difficult for patients to get the medication they needed, and that this problem was likely to worsen as the population ages.

But AMA President Dr Steve Hambleton said approving the Pathway was a dangerous decision that could lead to fragmented care and potentially put patients at risk.

"In the interests of patient safety, the AMA is strongly opposed to autonomous prescribing by non-medical health professionals," Dr Hambleton said.

He said the AMA had argued "long and hard" against the idea throughout the year-long consultation process undertaken by Health Workforce Australia (HWA) because of the likelihood that it would compromise health care.

An advisory group of health professionals formed to advise the HWA on the addressing barriers to care included some who backed the autonomous model, by the AMA's representative on the group, Dr John Gullota, steadfastly opposed the idea.

"HWA should not have put the autonomous prescribing model to the Health Ministers as an option," Dr Hambleton said. "It was very poor advice. Autonomous prescribing encourages fragmented health care and poses greater risks to patient safety."

He said the AMA supported prescribing by non-medical health professionals, but only when it was carried out within strict collaborative care arrangements in partnership with doctors.

Dr Hambleton said most prescribing by non-medical health professionals occurred in public hospitals, where strict protocols were in place.

He said the prescribing competency framework developed by the National Prescribing Service last year should be upheld.

"This framework sets high standards for prescribing that are currently only met by medical practitioners."

State and Territory legislation permits certain non-medical health professionals to prescribe a defined range of medications, but unless this authority is also recognised by the Pharmaceutical Benefits Advisory Committee they are not able to prescribe medicines through the Pharmaceutical Benefits Scheme.

Adrian Rollins

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.

AMA moves to protect interests of rural GPs

The AMA has moved to protect the quality of rural health care by applying for a renewal of its authority to represent GPs working as visiting medical officers in country hospitals.

The Association has lodged an application with the Australian Competition and Consumer Commission for renewed authority to represent rural GPs providing VMO services in public hospitals and health facilities in rural and remote areas in their negotiations with State and Territory health departments.

The existing authority expires on 28 February next year, and the Association is anxious to ensure rural doctors working as VMOs are not left without industrial representation.

In its application, the AMA highlighted several benefits that had flowed to the broader community since the Association was granted negotiation authority in 2008.

These included more effective representation of rural doctors in their dealings with State and Territory health departments, reduced transaction times and costs for these departments when contracting GPs as VMOs, and improved retention of rural GPs working as VMOs in country public hospitals.

"These public benefits have been supported by experiences gained since the granting of the authorisation in 2008," the AMA said in its application, lodged on 30 October. "There are no appreciable public detriments which have flowed from the authorisation."

The Association said renewal of the authorisation was "vital" for rural GPs, because it would ensure continued legal protection for both them and those who act on their behalf in collective negotiations.

"In those jurisdictions where the authorisation has been relied on [in] the last few years, the AMA has been able to provide experienced industrial officers to negotiate on behalf of the GPs, saving time, money and frustration, and allowing doctors to focus on patient care," it said in the application.

If renewed, the authorisation would continue to be valid in all states and territories except New South Wales.

A determination on the application is expected to be made early next year.

Adrian Rollins

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Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Brian Morton	AMA Chair of General Practice	Teleconference with Dr Paul Bates of Bupa regarding private health insurance industry engagement with GPs	15/10/2013
Dr Ashish Jiwane	AMA Member	MSAC Review Consultation Committee for Paediatric Surgery	22/10/2013
Dr Chris Moy	AMA Member	NeHTA Clinical Usability Program Steering Group	22/10/2013
		Medicines Australia Code of Conduct Review Panel	30/10/2013
Dr Steve Hambleton	AMA President	NeHTA eMedication Management Governance Group	23/10/2013
Dr Robyn Langham	AMA Victoria	Medicines Australia Code of Conduct Review Panel	30/10/2013

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

NIB sees growth in medical travel, *Sydney Morning Herald*, 30 October 2013

NIB's executives have defended the insurer's plans to cash in on medical tourism. The Australian Dental Association and Australian Medical Association have said NIB would not be able to guarantee the quality of procedures.

Labor ignored multiple e-health alerts, *The Australian*, 4 November 2013

Health Minister Peter Dutton has announced a review of the PCEHR project. AMA President Dr Steve Hambleton has been appointed as part of the three-member review panel.

E-health system a $1bn scandal, *Australian Financial Review*, 4 November 2013

Health Minister Peter Dutton has launched an inquiry into the former Labor government's e-health record system. AMA President Dr Steve Hambleton, who is part of the inquiry, said it was important that recommendations were made "fairly quickly".

Study begins on sale of Medibank, *The Age*, 6 November 2013

The Federal government has started the process for the privatisation of Medibank Private. The AMA has warned that a sale could increase health insurance premiums by decreasing competition.

Heart disease claims Catalyst for ABC stoush, *Adelaide Advertiser,* 6 November 2013

The ABC's leading health expert Dr Norman Swan has accused the broadcaster's flagship science program of putting cholesterol patients at risk of death. AMA President Dr Steve Hambleton said medicos were under siege from patients questioning their statin medicines after watching the two-part program.

Hockey hands back tax breaks, *Hobart Mercury*, 7 November 2013

Treasurer Joe Hockey has decided to axe Labor's $2000 limit on tax deductions for work related self-education expenses. AMA President Dr Steve Hambleton said it had been a tax on learning that would have discouraged investment in skills and stifled excellence.

Sector hails removal of self-education cap, *The Australian*, 7 November 2013

The reversal of the $2000 cap on self-education expenses to help pay for the Gonski school reforms has been widely hailed as a vote for common sense. AMA President Dr Steve Hambleton said it was a very welcome outcome.

NIB site to rate health experts, *The Age,* 8 November 2013

Health insurer NIB has launched a controversial and long-mooted website that rates and compares the performance of allied health professionals such as dentists, optometrists and chiropractors. The AMA has been a vocal critic of customer comparison sites.

Live long, prosper in Mitcham, *Adelaide Advertiser*, 8 November 2013

According to the ABS, South Australians are living longer than their interstate counterparts, with a median age in the State of 83 years in 2012. AMA President Dr Steve Hambleton said health literacy, access to services, and socio-demographic background were all factors contributing to a long and healthy life.

Trapped in a hi-tech world, *The Daily Telegraph*, 9 November 2013

Tech-savvy kids now spend more time online or watching television than they do at school, and should be put on a media diet of two hours a day. AMA President Dr Steve Hambleton said children were growing obese because they spent too much time in front of screens.

It's in the genes, *Sunday Canberra Times*, 10 November 2013

Learning about your DNA can provide a health road map for your life. AMA President Dr Steve Hambleton said while DNA testing was promising, he urged caution in using the technology, giving its early stage of development.

Radio

Dr Steve Hambleton, ABC NewsRadio Sydney, 1 November 2013

AMA President Dr Steve Hambleton discussed GPs being able to directly refer patients for a Medicare-funded MRI scan. He said it was a good move by the Federal Government.

Dr Steve Hambleton, ABC NewsRadio Sydney, 4 November 2013

AMA President Dr Steve Hambleton discussed ABS data showing reduced smoking and improved diagnosis and treatment was reducing cancer death rates, but he warned those living in rural areas were not sharing in much of this progress because of many disadvantages.

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AMA IN THE NEWS

...CONTINUED FROM PAGE 15

Dr Steve Hambleton, Radio National, 4 November 2013

AMA President Dr Steve Hambleton said e-health potentially had great value for health professionals and patients, but only if it delivered improvements in the efficiency and accuracy of care.

Dr Steve Hambleton, ABC NewsRadio Sydney, 6 November 2013

AMA President Dr Steve Hambleton discussed the Federal Government's decision to get rid of Labor's $2000 cap on self-education expenses. He said this was a win for common sense.

Dr Steve Hambleton, 3AW Melbourne, 6 November 2013

AMA President Dr Steve Hambleton discussed an article which stated one doctor lodged bulk billing claims based on seeing 500 patients in one day. He said the doctor did see that many people, but it was associated with a company offering workplace health and safety services, including vaccination.

Dr Steve Hambleton, 1377 Melbourne, 7 November 2013

AMA President Dr Steve Hambleton discussed Joe Hockey's decision to axe the $2000 cap on tax deductions for self-education.

Dr Steve Hambleton, 2UE Sydney, 8 November 2013

AMA President Dr Steve Hambleton discussed a new report that showing that life expectancy rates in Australia were increasing. He said that we can live longer by following good health practices.

Dr Steve Hambleton, 2GB Sydney, 11 November 2013

AMA President Dr Steve Hambleton discussed children using smartphones. He recommended a two hour limit on smartphone use, and raised concerns that pornography was easy to find on the internet.

TV

Dr Steve Hambleton, ABC News 24, 4 November 2013

AMA President Dr Steve Hambleton discussed the Government's decision to order an independent review of electronic health records. He said the review, of which he is a part, should recommend ways to increase the efficiency of the system and allow GPs to access it simply.

Dr Steve Hambleton, Channel 10, 8 November 2013

AMA President Dr Steve Hambleton discussed the impact patients with diabetes have on hospitals. He outlined the complications associated with diabetes that meant diabetic patients clogged up hospitals.

Dr Steve Hambleton, Channel 9 Sydney, 9 November 2013

AMA president Dr Steve Hambleton discussed life expectancy in Australia. He said improved education and quality medical care have contributed greatly to a longer life.

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:

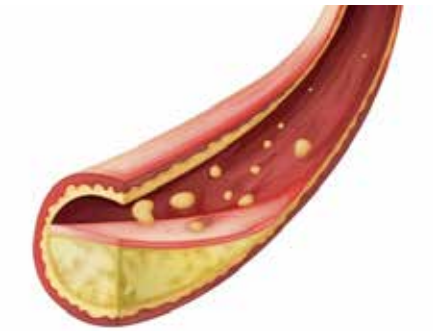
- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

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

Shaky statin claims spark rush to GPs



Doctors have been deluged with patients questioning their cholesterol medications following the national broadcast of a controversial program calling into doubt the benefit of statins.

Sydney GP and Chair of the AMA Council of General Practice, Dr Brian Morton is among many practitioners who have seen a stream of patients asking whether they needed to continue taking cholesterol-lowering statins after the ABC's science program *Catalyst* broadcast claims that cholesterol was not as harmful as had been made out, and the health benefits of statins had been exaggerated.

Dr Morton said that in the days after the program went to air on 31 October "just about everyone has come in to say, 'Should I stop taking them [statins]?"

AMA President Dr Steve Hambleton is among a chorus of health experts warning that people prescribed statins should not stop taking them just because of the Catalyst program.

Dr Hambleton said that if people were prescribed statins in accordance with national guidelines, then they should keep taking them because it would reduce their risk of a heart attack or stroke.

But while concerned about the potential for patients to be misled, the AMA President did not back the call of some for the two-part *Catalyst* program to be pulled altogether.

"I think we have to have a debate. And I think that there needs to be balance," he told ABC radio. "We need to, as medical professionals, justify why we choose drugs. We do criticise others for not acting on evidence. We need to be judged by the same criteria."

"So, if there's a good reason to take it, we should be able to explain it, and we should be able to explain the risks and the benefits of any treatment."

Claims made in the two-part *Catalyst* program have been roundly condemned by leading physicians and medical organisations, which have warned that they could cost lives. The ABC said it was investigating 90 audience complaints that the program did not meet quality standards.

The ABC's own medical expert, host of ABC Radio National's *Health Report*, Dr Norman Swan, launched a scathing attack on his *Catalyst* colleagues, warning that "People will die as a result of the *Catalyst* program unless people understand at heart what the issues are".

Dr Swan said that what made him "really angry" was how the show's claims might influence Indigenous patients, who are more likely to suffer from high cholesterol than the general community.

"If you were an Aboriginal person watching that program you would think: I don't need to be on cholesterol lowering medication, I don't need to worry about it," he said. "Cholesterol reduction is one of the few things that you can do for Aboriginal people safely, through statins which will save their lives, even though they have not had a stroke, because they are at high absolute risk."

"The take from the audience - at least anecdotally - was that cholesterol is not a risk factor at all: I can go back to the way I was, and that statins are evil drugs sold by the evil empire of the pharmaceutical industry," Dr Swan told the ABC audience.

"Let's be clear. When you reduce cholesterol, regardless of how you do it - whether it's by statins, by other drugs or by diet - if you reduce your cholesterol you reduce the rate of coronary heart disease, of heart attacks and strokes and death. The evidence is absolutely clear."

Statins are the most commonly prescribed subsidised medicine in the country, and on occasion are associated with severe side effects.

But National Prescribing Service Chief Executive Dr Lyn Weekes said cardiovascular disease was the country's biggest killer, and there was "strong evidence" that statins were effective in reducing the chance of having a heart attack or stroke, particularly for those already with the disease, or who have suffered a heart attack or stroke.

"If you have been prescribed a statin to reduce your risk of cardiovascular disease, it is important that you keep taking your medicine as directed," Dr Weekes said. "Statins have been shown to reduce the chance of having a first heart attack

In an article in *MJA Online*, nutritionist Rosemary Stanton highlighted the background of those featured on the Catalyst program.

The show, Dr Stanton said, "relied on the opinion of a journalist and four US experts — a nutritionist, two cardiologists and a physician — but failed to note that three of the experts market a range of "alternative" products via their websites, (www.jonnybowden.com, www.drsinatra.com, www.proteinpower.com), including diet "aids" (with "slimming" claims), anti-ageing, "brain power" and detox supplements, plus a variety of bars, shakes, drinks and powders".

"One product even claims its citrus bergamot content will lower triglycerides, blood sugar and inflammatory LDL (low-density lipoprotein) cholesterol and raise HDL (high-density lipoprotein) cholesterol," Ms Stanton said.

See also "Some things you should know about statins and heart disease", p22.

Adrian Rollins

TO COMMENT CLICK HERE

Ratings website a crude barometer of care

"You make 10 people happy, one of them sends you a thank you," he said. "If you make one unhappy, they might tell 10 people. Online rating sites can often slip into berating sites"

The AMA has warned that a website developed by health fund NIB to rate the service provided by dentists, optometrists and other health professionals could provide consumers with misleading information.

Earlier this month NIB launched its Whitecoat website, which lists contact details and patients reviews for around 30,000 ancillary health care providers.

The health fund said it had established the website, which has been under development for three years, in response to requests from its members looking to find and compare ancillary providers.

In addition to publicly-available contact information, for each provider the website includes three indictors of service – a Comparative Cost Score, a Likelihood to Recommend Score and individual patient reviews.

Comparative Cost is rated on a scale from 1, indicating low average charges, to 5 (high average charges), which reflects the weighted average fee charged for the most commonly used services offered by each provider.

The Likelihood to Recommend Score is based on patient reviews, and is on a scale from 0 (not likely to recommend) to 10 (highly likely to recommend).

NIB said these ratings would be particularly useful for patients who have moved into a new area, or need specialist treatment for the first time.

NIB Group Manager for Australian Residents' Health Insurance, Rhod McKensey, said that, so far, feedback on the website about practitioners had been "90 per cent positive".

Mr McKensey said the website only published contact information that was publicly available through Sensis, and providers had the option to opt out of having their Comparative Cost and Likelihood to Recommend scores, as well as any patients reviews, published on the website.

While GPs and medical specialists are not included in Whitecoat, AMA President Dr Steve Hambleton has voiced serious concerns about the usefulness and accuracy of information provided on such comparative websites.

Dr Hambleton told the ABC such websites were more likely to generate negative rather than positive feedback.

"You make 10 people happy, one of them sends you a thank you," he said. "If you make one unhappy, they might tell 10 people. Online rating sites can often slip into berating sites."

The AMA President has previously said that the experience of every patient is a personal one and, without context, crude ratings were of limited value.

He cited the example of an obstetrician who, because of the quality of their work, attracted many of the most difficult cases. This fact alone meant there was a greater risk of this practitioner having more adverse outcomes than an obstetrician who took on less complex cases.

Adrian Rollins

TO COMMENT CLICK HERE

Antibiotic resistance takes flight as disease threat mounts

Evidence that wild birds are carrying drug-resistant bacteria has heightened fears about the overuse of antibiotics.

As international Antibiotic Awareness Week begins, researchers in the United States have found that wild crows are carrying bacteria resistant to the antibiotic Vancomycin in their gut.

While microbiologists and immunologists are yet to assess the full implications of the discovery, it has highlighted concerns that extensive use of antibiotics in health and animal husbandry is fuelling drug resistance and leaving humanity increasingly at risk from untreatable bacterial infections.

Researchers at Tufts University in Massachusetts unexpectedly found genes for resistance to Vancomycin – for many years viewed as a drug of last resort in treating bacterial infections – in the faeces of crows from widely dispersed populations in the United States, according to online news service *Environmental Health News*.

The researchers were particularly alarmed by evidence that some of the Vancomycin-resistant bacteria identified were also resistant to several other antibiotics widely used in human medicine and animal husbandry.

Around 27,000 tonnes of antibiotics are used in farming in the United States to prevent and treat disease and promote growth in livestock. This is in addition to the large quantities administered to humans.

The discovery follows warnings issued by infectious disease experts earlier this year that increasing antibiotic resistance posed a "catastrophic threat" that could make even minor and routine medical procedures deadly.

Britain's Chief Medical Officer Professor Dame Sally Davies said humanity risked "losing the war" against potentially deadly bacteria because of increasing resistance to a wide array of antibiotics and a "discovery void" in the development of new drugs.

Australasian Society for Infectious Diseases President Associate Professor David Looke said unfettered use of antibiotics in both animals and humans, especially in the developing world, had driven an "alarming" upsurge in levels of antibiotic resistance.

The Atlanta-based Centers for Disease Control and Prevention has estimated that every year at least two million people in the United States become ill with infections resistant to antibiotics, and that around 23,000 die as a result.

In an effort to combat the rise of antibiotic resistance, the National Prescribing Service (NPS) is urging medical practitioners and patients to mark international Antibiotic Awareness Week (18-24 November) to join its antibiotic resistance campaign.

The NPS has invited doctors to make a pledge to fight against antibiotic resistance by visiting the website www.nps.org.au/antibiotics.

After making a pledge, medical practitioners will be able to generate a personalised antibiotic resistance fighter certificate for display in their workplace, and the first 3000 to make the commitment will also be able to order a free Resistance Fighter t-shirt.

In addition, 15 Australian and New Zealand companies manufacturing and fabricating equipment and fittings used in hospitals, medical clinics, aged care centres and schools have joined forces to promote the use of antimicrobial copper in everything from taps, door handles, light switches and bench tops through to beds and IV poles.

The copper is claimed to kill many bacteria and viruses on contact, slashing infection rates.

Adrian Rollins

TO COMMENT CLICK HERE

Here's to a long, healthy lifestyle

Obesity is shaping as the biggest obstacle to humans reaching a life span of 150 years or more, AMA President Dr Steve Hambleton has warned.

Commenting on official figures showing that average life expectancy has increased by two-and-a-half years in the past decade, Dr Hambleton said it would become increasingly commonplace for people to live well beyond 100 years.

"The person who will live to 150 [years] has already been born," the AMA President told the *Daily Telegraph*. "The only obstacle may be obesity. Obesity has been proven to increase cancer, diabetes and cardiovascular disease. As long as we take it seriously, our life expectancy will continue to increase."

Less than 147,100 people died last year, a bare 0.1 per cent increase from 2011, while during the same period the population grew by 1.8 per cent, according to the Australian Bureau of Statistics.

The figures reflect great strides that have been taken in reducing infant mortality, which has fallen from five deaths per 1000 live births in 2002 to 3.3 per 1000 live births last year. Much of this improvement has been achieved in the Indigenous community, where the infant mortality rate halved in the 10 years to 2012 from 12.6 to 6.4.

But more people at all ages are surviving. The nation's standardised death rate has shrunk from 6.8 per cent 1000 people in 2002 to 5.5 in 2012.

Improvements in survival rates at all ages have been reflected in a shift in the age groups in which most deaths occur.

In 1975, the mode of mortality among men was in the 70 to 74 years age group, which accounted for 8450 of all male deaths, while among women it was in the 80 to 84 years age bracket.

By 2012, the mode of mortality for both genders had advanced. Among men, it was the 80 to 84 year age group, closely followed by the 85 to 89 year age bracket, while among women it was the 85 to 89 year age group.

The ABS said improvements in survival rates meant that a boy born between 2010 and 2012 could expect to live, on average, 79.9 years, while a girl born at the same time could expect to live to 84.3 years.

Despite the overall improvement in survival rates, the ABS data showed that in recent years deaths among children have been growing at a faster pace than the rest of the population.

Though still small in absolute terms, the number of 10 to 14-year-olds who died in 2012 jumped 6.8 per cent, and by 4.8 per cent among 15 to 19-year-olds.

Dr Hambleton said the biggest single cause of deaths in older children was accidents, and it was important to examine the underlying causes "to make sure we are not exposing our children to danger".

Adrian Rollins

TO COMMENT CLICK HERE

'Angelina effect' drives women to test their genes

Referrals to genetic testing clinics trebled in the days after actor Angelina Jolie went public with her decision to have a preventive double mastectomy, a scientific meeting has heard.

Ms Jolie drew international attention to the risk of genetic predisposition to breast cancer when she announced her decision, prompting a surge in the number of women seeking genetic tests, according to Peter MacCallum Cancer Centre senior genetic counsellor Mary-Anne Young.

Ms Young told the Clinical Oncology Society of Australia's Annual Scientific Meeting on 13 November there had been a marked "Angelina effect" on the rate of genetic testing since the actor revealed her decision.

Ms Young said that in the six weeks prior to Ms Jolie's announcement, genetic clinics in New South Wales, Victoria and South Australia had received around 90 referrals a week.

But in the immediate aftermath of her disclosure, referrals spiked up to around 280 week, and since have settled at around 190 a week.

Ms Young told the *Sydney Morning Herald* that many of the women being referred for genetic counselling had a high risk of developing breast or ovarian cancer due to a strong family history, and Ms Jolie's case had given them the prompt they needed to seek advice.

"We have seen people who knew they were from high-risk families but they just hadn't been as proactive as they might have been," she said.

"The majority of the referrals we're getting, around 80 per cent, are related to a family history of breast and ovarian cancer," Ms Young told the meeting.

Ms Jolie revealed in May that she had had a double mastectomy after genetic tests revealed she carried the BRCA 1 gene and had an 87 per cent chance of developing breast cancer and a 50 per cent chance of ovarian cancer.

Ms Young said women carrying BRCA 1 and 2 genes were at a significantly greater risk than the general population of developing breast and ovarian cancer. Options to reduce this risk included regular screening, preventive mastectomy or risk-reducing medication, she added.

The Society's President, Associate Professor Sandro Porceddu, said about 5 per cent of the 15,000 breast and ovarian cancer cases diagnosed in Australia each year were attributable to an inherited gene, and he encouraged those with a family history of the diseases to speak to their GP.

"Being aware of a genetic risk means patients are more likely to either avoid cancer or detect it at an earlier stage, when treatment is more likely to be successful," Associate Professor Porceddu said. "Ultimately, this greater awareness of genetic risk will save lives."

Adrian Rollins

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

Since the Service was launched in September 2012, AMA Careers Consultant, Kathryn Morgan, has handled dozens of inquiries from members looking for help and advice on advancing their careers, both within medicine and beyond.

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

Some things you should know about statins and heart disease

BY IAN HAMILTON-CRAIG, PROFESSOR OF PREVENTATIVE CARDIOLOGY, GRIFFITH UNIVERSITY

The article first appeared in The Conversation on 31 October, 2013, and can be viewed at https://theconversation.com/some-things-you-should-know-about-statins-and-heart-disease-19655

Cardiovascular disease (heart attack and stroke) causes the most deaths in Western countries overall, and the vast majority of premature deaths. Statins have been the cornerstone of how we treat people at risk of such deaths, and they've made a huge difference to survival rates.

Statins are the most widely prescribed medication in Australia, where 45,600 people (31 per cent of all deaths) died of heart attacks and strokes in 2011. In 2010-11, statins were taken by an estimated 2.6 million Australians (mean age 67 years, with mean age for starting treatment 58 years).

Risk factors for heart disease include age, being male, smoking cigarettes, high blood cholesterol, diabetes, and high blood pressure.

Rates of cardiovascular disease have fallen with improved control of these risk factors through dietary changes and drug treatment, including statins; between 1991 and 2002, deaths from cardiovascular disease fell by 36 per cent in men and 34 per cent in women.

Statins are indicated for an absolute five-year cardiovascular disease risk of great than 15 per cent, according to National Vascular Disease Prevention Alliance guidelines.

Heart health and cholesterol

Statins work by lowering blood cholesterol levels, especially the levels of low-density lipoprotein (LDL).

A small amount of low-density lipoprotein is essential for life as it delivers cholesterol to tissues, which use it to maintain cell membrane structure, to synthesise hormones, and to allow cells to proliferate. But too much of it is bad because it promotes the formation of plaques in coronary arteries.

Indeed, high blood levels of LDL cholesterol are directly correlated with increased rates of coronary disease (heart attack, angina, heart failure, and sudden death) and stroke.

When LDL cholesterol accumulates inside the walls of the arteries to the heart and brain, it forms plaques and results in atherosclerosis (narrowing from plaque formation). Atherosclerotic plaques gradually enlarge and narrow the artery. If they rupture, blood flow to the heart or brain can suddenly be blocked, resulting in heart attack or stroke.

High levels of LDL allow cholesterol accumulation inside cells, starting (or continuing) the process of plaque build-up. Statins reduce the risk of cardiovascular disease by reducing LDL levels, and improve survival for people at high risk of cardiovascular disease.

They reduce the liver's synthesis of cholesterol and, in response, the liver up-regulates its LDL receptors, restoring cholesterol levels in the liver, and reducing blood levels of LDL.

Enter statins

Many things can affect blood LDL cholesterol levels, including genetic disorders. Familial hypercholesterolaemia, for instance, results in reduced LDL receptor function and high levels of LDL cholesterol. This, in turn, increases the rate of coronary disease.

A 2008 UK study found the death rate in people with familial hypercholesterolaemia was 37 per cent higher before statins were available.

Statins were originally used to treat people with genetically high LDL cholesterol levels, and were found to be more effective than previous drugs. They also had fewer side effects.

They are now used to treat people at high risk of heart attacks and strokes based on the results of many clinical trials showing reduced risk with statin treatment.

The benefits of statins include fewer heart attacks and strokes, and improved survival for people at highest cardiovascular risk.

A 2012 study of 27 randomised control trials for statins showed a 24 per cent reduction in relative risk per unit of LDL (the difference in rates of cardiovascular disease between groups receiving statins and control groups).

The absolute risk reduction (difference in absolute rate of cardiovascular disease between the statin and control groups) is, naturally, greater in those at higher baseline risk. You'll recall that the baseline risk is affected by such factors as age, gender, smoking habits, blood pressure, cholesterol levels and whether you have diabetes.

Statins also reduce the risk of cardiovascular disease in people at very low risk (less than 10 per cent). But even though they may benefit from statins, whether these low-risk people should take them is a matter for health economists and ethicists to consider.

Statin prescriptions in Australia are usually reimbursed for those at highest cardiovascular risk, independent of blood cholesterol levels. People at intermediate risk are reimbursed depending on their blood cholesterol levels.

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Reform can fix health gap

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Statins' side effects

All medicines have potential side effects and statins are no exception. That's why there are guidelines for statin use.

One significant side effect of statins is the risk of developing diabetes, especially if you are overweight. In the approximately 250,000 people treated with the drugs in 135 randomised trials, there was a 9 per cent increased risk of developing diabetes compared with the rest of the population.

But this increased risk is outweighed by the benefits statins have for heart health in high-risk people.

The authors of a meta-analysis of 27 clinical trials of statins found the risk of cancer was not increased. They also found that statins were well tolerated, with no evidence of increased muscle side effects, and only a slight increase in liver enzymes (transminases) that can indicate it's damaged.

These data differ from the "real world" experience, as a study 7924 people treated with high dose statins showed. In this study, 10.5 per cent of people taking statins complained of muscle symptoms (pain, aches, stiffness, weakness, fatigue, cramping and tenderness), usually within a month after starting to take the drugs.

These symptoms were severe enough to prevent moderate exercise in 38 per cent of the people in the study, and 4 per cent were unable to work, or were confined to bed.

Risk factors for developing muscle symptoms included a history of muscle pain with other similar therapy (ten times more likely), unexplained cramps (four times more likely), a family history of muscle symptoms (twice as likely), and low thyroid activity (70 per cent more likely).

People at most risk of side effects are the elderly (older than 75 years), because they metabolise the drug less efficiently, so there's a higher level of statins in their blood, predisposing them to muscle toxicity. People with lean muscle mass, and risk factors for muscle symptoms outlined above, are also more likely to suffer these side effects.

Other people also at risk are those taking drugs that may raise blood levels of certain statins, liver or kidney disease, those taking high-dose statins, and those undertaking high levels of physical exercise (because it predisposes them to getting the muscle symptoms).

For these people, lower doses of statins with close monitoring may be the best way to proceed, or they may need to try alternative therapies.

Statins have made a big difference to evidence-based preventative medicine. And they have improved the quality of life for many people who would have otherwise suffered debilitating cardiovascular disease.

The current debate about statins sparked by controversial claims of over-prescribing in the ABC science show gives doctors the opportunity to assess absolute risk in their patents.

Doctors should also take this opportunity to review possible statin-related symptoms in patents taking the medication. These may have been present but ignored by either patient or doctor previously - with the caveat that placebo-treated patients in clinical trials also complain of treatment-related symptoms.

TO COMMENT CLICK HERE

Double billing or appropriate billing?

BY **DR BRIAN MORTON**

"GPs will be unable to claim legitimately for MBS items for two distinct, clinically necessary services at the one consultation"

It's a daily occurrence at most surgeries, including mine – the patient with a chronic illness who comes to see you and legitimately needs care on an unrelated condition.

Or it could be the patient who comes in with gastro but mentions problems with their diabetes. You realise that their care plan needs to be updated. You weigh them and check their blood pressure. Then there are the tests that need to be organised.

Some GPs will absorb the cost of the extra care and charge for one service – a common practice in disadvantaged areas. Others will ask the patient to return for a new appointment.

Alternatively, some GPs will claim a standard consultation and a chronic disease management item for the patient on the same day.

Well, not for much longer. The Government will block this practice from 1 November 2014.

The Government sees it as double billing. I call it appropriate billing.

There are times when it is legitimate to co-claim for two services provided at the same consultation.

The change is happening because the previous Government wanted to save almost $120 million in coming years by cracking down on what it believed was inappropriate billing by doctors treating patients with chronic ailments.

The AMA understands that the Department of Health has identified opportunistic billing by a small minority of doctors, but it had not brought the problem to our attention before the measure was announced in this year's Federal Budget.

This issue generated quite a lot of discussion at the recent meeting of the AMA Council of General Practice.

Providing a consultation with a chronic disease management (CDM) item is not a common or routine practice for the majority of GPs.

I don't co-claim often. But there are occasions when it becomes apparent during a consultation that my patient needs a care plan. For some of these patients, I think it would be an unfair impost to ask them to come back for another appointment. They may be elderly or have limited transport.

My colleagues who work in underprivileged areas with a high incidence of co-morbidities tell me that they tend to co-claim more often. Others say that they are booked out for weeks in advance, and their patients use the opportunity to discuss multiple issues during their consultation. Some will require care plans. The crackdown will have a disproportionate effect on these patients.

Perhaps the bureaucrats making these decisions should visit busy practices in disadvantaged suburbs or towns to see what doctors are facing in reality.

The crackdown on co-claiming is the latest in a long line of cuts to general practice items.

As with the decision in 2009 to remove MBS items for joint injections, this blanket measure has been foisted on the profession with little consultation. And with no consideration of the consequences.

GPs will be unable to claim legitimately for MBS items for two distinct, clinically necessary services at the one consultation.

This will create a situation where patient out-of-pocket expenses rise, increasing the risk that they will reduce or stop their treatment. GPs will be obliged to do more for less.

This is a budgetary measure and the die is cast, but I am hoping that the AMA will have the opportunity to moderate the measure and lessen the impact on patients and GPs.

While the Department says that it has evidence of inappropriate billing, it seems reluctant to try and tackle this or undertake further education. Unfortunately it finds it easier to undertake a blanket cost-cutting exercise.

We believe that the best approach is to modify the existing CDM items using the same provision that applies to health assessments – consultation items may not be billed with CDM items unless it is clinically necessary.

This would be a simple and sensible solution to the problem identified by the Department. One that would not disadvantage GPs or our patients.

TO COMMENT CLICK HERE

Queensland Health contracts: radical, unfair, unhealthy

BY **DR STEPHEN PARNIS**

The Queensland Government, based largely on the recommendations of a Commission of Audit led by Peter Costello, is implementing an outrageous policy of forcing Senior Medical Officers in the Queensland public health system onto individual contracts.

The policy, as outlined in the Queensland Health document *Blueprint for better healthcare in Queensland.* Broadly, will see Senior Medical Officers (SMOs) removed from award coverage, stripped of collective rights and denied access to the Queensland Industrial Relations Commission.

The whole proposal is being underpinned by legislative amendments being rushed through Parliament. It is, as far as I am aware, unprecedented in Australia, and is the result of absolutely no consultation with stakeholders.

The proposal, which has been identified as a priority by Queensland Government, is for existing conditions and protections embedded in awards and agreements to be removed by transferring senior medical staff on to contracts.

The AMA Council of Salaried Doctors has unanimously condemned the approach of the Queensland Government.

AMA Queensland has been working with the Australian Salaried Medical Officers Federation (ASMOF) (Qld) to analyse the proposal and respond to it. They have identified a range of concerns with the proposed contracts, which include:

- the lack of a dispute resolution clause, which is unusual for an employment contract;
- there denial of access to the Queensland Industrial Relations Commission;
- the contract does not reference ASMOF or any union;
- salary and tiered arrangements for payment are completely discretionary for the employer;
- Rights of Private Practice will be removed. Private practice will only be allowed if agreed to by the employer;
- rates and allowances will be set by a governance committee, with no guarantee of annual indexation;
- individual contracts will reduce remuneration and rights, especially regarding overtime, on-call and hours of work provisions;
- the employer can impose a roster on salaried and visiting medical officers without reasonable consideration being given to hours of work or fatigue; and
- there is no means of collective renegotiation, or a mechanism to oversee the implementation of contracts.

These are just the issues specific to the contract itself.

Of course, more broadly, the concern is that the contracts diminish the collective bargaining rights of the doctors involved and create an imbalance in the power between the parties.

This is totally inconsistent with fair work practices, and leaves employees vulnerable, confused and with less time to devote to their core duty of patient care.

This duty of care will suffer even further as unpredictable rostering and overall dissatisfaction pervade the system.

What this means is that individuals will have to negotiate with the State, if indeed there is any room for negotiation at all. This is not only inefficient and daunting, but costly as well. Anyone who has negotiated with State entities will tell you that it can be a frustrating process.

ASMOFQ and AMAQ are currently considering their options in responding to the contract.

The Government wants the system to be implemented by mid-2014, leaving little time for doctors to consider their options, given the major cultural shift involved.

To date, there has been no meaningful engagement by the State Government with AMA Queensland or the ASMOFQ on the contracts, the enabling legislation or changes to private practice.

I cannot say it loudly or clearly enough: these contracts are unfair from a legal, industrial and health care point of view. They threaten the wellbeing of doctors in the public health system, as well as that of their patients.

I doubt whether the supposed short term gains will be sustainable or worthwhile, as many doctors are likely to leave the Queensland public health system when faced with a deal like this.

The Newman Government has an overwhelming majority in Parliament, and these proposals reflect what appears to be a take-it-or-leave-it approach which, unfortunately, is likely to damage the provision of health care in Queensland for years to come.

TO COMMENT CLICK HERE

The doctors are not alright

BY **CHAIR DR WILL MILFORD**

"Recently one of my colleagues told me that they are emotionally incapable of caring for their patients any more. How can I help them?"

This question, or something very similar, was put to one of the plenary speakers at the recent Prevocational Medical Education Forum in Adelaide. It highlights the crisis affecting junior doctors around Australia and, importantly, the direct effect it could have on patient care.

A recent beyondblue survey contained a number of important findings lifting the veil on the true state of mental health among Australia's doctors and medical students.

The survey reported a number of telling findings, including:

- that psychological distress was greater among trainee doctors than than those in the later stages of their careers, and that doctors generally reported significantly higher levels of psychological distress compared with the general population;
- that signs emotional exhaustion, cynicism, feelings of depersonalisation and low professional efficacy - all symptoms of burnout - were greatest among younger doctors: 40 per cent of trainees and 45 per cent of interns displayed high emotional exhaustion;
- the general work experience for Australian doctors is stressful and demanding. Work-related factors such as hours worked, training stage and burnout were associated with high likelihood of psychiatric distress, reflecting the significance of work-related factors; and
- stigma regarding the performance of doctors with mental health conditions persists.

More reassuringly, a significant proportion of doctors with mental health problems sought advice and treatment. Similarly, doctors suffering mental health distress appeared to be relatively resilient to its effects.

Overall, these statistics are an indictment of the conditions that junior doctors work in. What other profession would accept similar levels of work-related distress?

It is unclear whether this is a longstanding situation, or is the manifestation of increasing pressures within the health care system more generally. Similarly, it is unclear whether such widespread distress is because today's graduates are more susceptible or more poorly prepared than their historic peers.

Of the conclusions of the survey, the reflection that transitioning from study at medical school to working as a junior doctor in a public hospital is a period of significant stress is particularly powerful. This recognition implies that greater efforts should be made by both universities and hospitals to support doctors through this time.

Recommendations that address the stressful working environment must be acknowledged and acted upon.

Given the current workforce situation, the raw materials are present to easily increase human resources, enlarge the workforce and improving work-life balance.

Increasing the role of mentors and role models, and improving their accessibility, will also be an important part of the solution.

Providing sufficient resources to medical education departments, including recognition that medical education officers provide crucial pastoral care for junior doctors, must also be a priority. Appreciation of the role these individuals play in public hospitals is long overdue.

Similarly, the survey should act as a driver for medical schools to improve the preparedness of their graduates for the demands of work, especially in terms of improving their ability to cope with stress. This should include emphasis on the importance of seeking support when needed. Indeed, one of the priorities for AMA Council of Doctors in Training in coming months will be ensuring that both medical schools and public hospitals recognise their responsibilities in responding to the recommendations of the report.

Returning to question at the beginning of the column, the answer given by the speaker, Dr Robin Youngson, was an innovative yet obvious one: compassionate care, for both doctor and patient.

Dr Youngson was speaking on behalf of Hearts in Healthcare (heartsinhealthcare.com), a movement attempting to increase the humanity in health care.

In a powerful lecture, he reflected upon the importance of fostering compassion, which delivered measurable benefits in terms of both patient care and the enhanced wellbeing of doctors, especially in terms of stress and burnout.

A key conclusion was the importance of being 'valued', especially for junior doctors and students.

While being valued by patients is probably beyond our control, being valued by peers, more senior medical practitioners and the institutions in which we work, is part of the culture of the workplace, and often neglected in resource-poor, busy departments.

So, next time you work with a junior doctor, make them feel valued. Bring compassion to your workplace, not just for your patients, but for the doctors you work with.

After all, if we don't care for our junior doctors, how can we expect them to care for patients?

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Training opportunities key to closing health gap

BY AMA PRESIDENT DR STEVE HAMBLETON

"Research shows that chronic disease deaths could be halved among Aboriginal peoples and Torres Strait Islanders by timely and systematic diagnosis, and within a short period of time also"

There are many factors contributing to the gap in health and life expectancy experienced by Aboriginal peoples and Torres Strait Islanders. These factors range from the adverse health impacts of early life circumstances, right through to the high prevalence of chronic cardiovascular diseases.

Research shows that chronic disease deaths could be halved among Aboriginal peoples and Torres Strait Islanders by timely and systematic diagnosis, and within a short period of time also. Similarly, appropriate culturally safe support from trained health and medical professionals for mothers and babies in the early years could ameliorate the life-long health impacts of a poor start in life for Aboriginal and Torres Strait Islander children.

A proper supply of health practitioners and medical professionals working with Aboriginal and Torres Strait Islander communities would go some way to breaking this circuit of poor health. However, what is most needed, but is in limited supply, are health and medical professionals who are fully skilled in best practice service provision to Aboriginal people and Torres Strait Islanders.

We know what best practice models of primary health care for Aboriginal people and Torres Strait Islanders involve (the AMA published a major report on this in 2011-12). But there are very few opportunities for doctors and health practitioners – either in training or once qualified – to gain hands on experience and excellence in skills and knowledge working in real situations with expert practitioners and researchers doing cutting edge work in Aboriginal health.

To rectify this the AMA believes that there is a great need for centres of excellence in Aboriginal and Torres Strait Islander health which can:

- conduct research on models and approaches to health conditions and risks besetting Aboriginal people and Torres Strait Islanders;
- provide best practice primary care services based on that research;
- provide practical training and experience to doctors, health professionals and trainees who take visiting placements at the centres for varying periods of time; and
- offer accreditation in Aboriginal and Torres Strait Islander health to those centres which take placements and meet requirements.

The AMA believes there needs to be a national network of these Teaching Health Centres of Excellence, given that different areas of Australia have different Aboriginal and Torres Strait Islander populations with different characteristics and needs.

To fulfil all the above roles, each Teaching Health Centre of Excellence would need to be formed as a collaboration between Aboriginal community-controlled health services, government health services and clinics, and universities involved in teaching and applied research in Aboriginal and Torres Strait Islander health.

Practical teaching would encompass students from medicine, nursing, allied health and Aboriginal Health Workers at Diploma, Advanced Diploma, Graduate and Post-Graduate level. As students and visiting doctors pass through these centres of excellence and take their posts up elsewhere, they could take back with them knowledge, skills and expertise in the delivery of high quality, culturally competent primary care.

The AMA has advocated for the establishment of a national network of Teaching Health Centres of Excellence in the past, and has resolved to impress upon the new Federal Government the need for these centres of innovation to close the gap.

TO COMMENT CLICK HERE

To be, or not to be...

BY **PROFESSOR STEPHEN LEEDER**

"Medicare contains no incentives to improve the quality of patient care"

Recently I saw *Hamlet* at Sydney's Belvoir Theatre. As the blurb says 'Director Simon Stone is ruthless and visionary in his pursuit of the essential in a text; Toby Schmitz [Hamlet] is one of the great actors of his generation: quick, droll and fiendishly sharp.' I admit no conflict of interest: it is simply brilliant. In Hamlet's day, all was not well in the state of Denmark.

Coincidentally, Crown Prince Frederik and Crown Princess Mary, members of today's royal court of Denmark, were in town for the 40th birthday celebrations of the Sydney Opera House, its architect being the great Dane, Jørn Utzon. Their generous visit to the Winmalee fire victims in late October was matched by Mary's gift of her bouquets to patients in Westmead Hospital's cancer centre named in her honour in 2011. The state of Denmark was looking good.

The complexity of large institutions, be they Denmark or Medicare, is that simultaneously you can find in them both healthy and unwell bits. Medicare still removes financial barriers to medical and hospital care in Australia, but other parts of it are problematic.

MJA InSight, an on-line news and commentary channel affiliated with *The Medical Journal of Australia*, recently conducted a poll among readers about Medicare. Should the new federal government undertake a major review of Medicare, readers were asked.

The voting options and responses were as follows: Yes, long overdue - 75 per cent; yes, with reservations - 28 per cent; no, leave it alone - 22 per cent.

All is not well in state of Medicare, at least as viewed by the readers of MJA InSight.

Now, I fully accept that these opinions are not representative of all doctors or of Medicare users. Let's regard them as indicators. What might the new Federal Government consider were they to undertake a major review of Medicare?

I asked Dr Anne-marie Boxall, director of the Deeble Institute for Health Policy in Canberra and co-author, with policy academic Jim Gillespie, of a new book entitled *Making Medicare*, for her ideas. Her book chronicles the evolution of Medicare from its inception as Medibank to the present.

Dr Boxall suggested that a thoroughgoing review of Medicare was warranted, and should consider three related priorities.

First, the relation between Medicare and private health insurance should be reassessed. Health care in Australia is funded and delivered by both the public and private health sectors, frequently in combination. They are not discrete and unrelated systems and, to avoid inefficiencies, insurance for access to both public and private care should be considered together.

Second, a critical review is needed to ascertain what is really happening about access to care. Medicare at present assures access to many services without charge – bulk billing general practitioners and public hospitals, for example. But many other vital health care services are not funded through Medicare, or incur an additional cost. The limitations of Medicare, particularly in the management of chronic illness, and in the private sector, should be defined, and creative ways searched out to improve access to care. These new ways may be financial, but are likely to include new policies for medical workforce development and deployment.

Third, and none-the-less important for that, the new Federal Government would do well to ensure that a review of Medicare takes the matter of quality in health care seriously. The original purpose for Medicare was to enable unfettered access to health care. It was not designed to deal with what happened when access was achieved, what went on in the therapeutic transactions to which it gave access.

But the scene has changed, and the close association between paying for care and assuring quality is much more in focus worldwide.

Medicare contains no incentives to improve the quality of patient care. Over time, governments have tried to stimulate quality improvements, but these have stood alongside financing arrangements rather than being supported by them.

Medicare remains an icon of Australian health care. But all is not well within its estate. Clever diagnosis and the correct prescription are needed to bring the system back to better health.

TO COMMENT CLICK HERE

Health on the hill

Political news from the nation's capital

Health Ministers mull vaccination rules for schools

The nation's Health Ministers have rejected suggestions that children who are not fully vaccinated should be banned from attending school.

But, in an acknowledgement of mounting community concern about the threat posed by areas of low vaccination coverage, the Ministers have agreed to work on the development of nationally-consistent immunisation requirements.

As the Ministers met in Hobart on 8 November to discuss the National Immunisation Strategy, evidence emerged that a community health group funded by the NSW Government encouraged parents to seek advice from an anti-vaccination lobby group.

A *Medical Observer* report said the carers support service Working Carers Gateway provided a link to the Australian Vaccination Network, an anti-vaccination campaign group, on its website.

The link was provided as part of advice to parents on new requirements that proof of vaccination be provided in order to have children enrolled in child care.

In its advice to carers, the website said its information might be of interest to "working carers who… have chosen not to vaccinate their child for health contra-indication reasons".

According to the *Medical Observer*, the Gateway also advised that the AVN website was "one of the few sites where you can find information about the ingredients in vaccines and their potential harmful effects," and provided a link to the AVN website.

This reference to the AVN has since been removed from the Gateway website, which carries the NSW Department of Family and Community Services logo.

Sensitivity over immunisation rates has been heightened by warnings parts of the nation are vulnerable to sustained outbreaks of measles, whooping cough and other serious diseases because of low vaccination rates.

An Australian Council of Australian Governments report released last month found infant vaccination rates in parts of NSW have declined from already low levels, and in Queensland just 82.5 per cent of four-year-olds are fully vaccinated.

Earlier this year, the National Health Performance Authority reported that almost 77,000 children nationwide were not fully immunised in 2011-12.

At their meeting earlier this month, the Federal, State and Territory Health Ministers "noted" the National Immunisation Strategy, which has as its priorities the operation of a secure vaccine supply, improved vaccine safety monitoring, strengthened evaluation of the National Immunisation Program and the provision of an adequate immunisation workforce.

While rejecting a national ban on school entry for children who are not fully vaccinated, the Ministers agreed to "a stocktake and review" of school entry immunisation requirements from across the country "to identify suitable models of use at a national level".

Adrian Rollins

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Voters sceptical of Medibank privatisation

Voters share the AMA's lack of enthusiasm for the privatisation of Medibank Private, with almost half voicing outright opposition to the idea, according to a survey by pollster Essential.

In a result that suggests the Abbott Government faces a tough task if it wants to win over voters to the proposed privatisation of the nation's largest health fund, the poll of 1000 voters found just 22 per cent supported the move, while 43 per cent objected to it, with the remaining 35 per cent uncommitted.

According to the Essential poll, even Coalition voters were unconvinced - fewer than 33 per cent thought it was a good idea.

The results echo the AMA's caution over the proposal.

Ever since sale legislation was first introduced in 2006, the Association has voiced concerns that it could lead to higher premiums by reducing competition in the private health insurance market, saddling the eventual buyer with heavy debt servicing obligations and possibly exposing the health fund to offshore financial risk.

The Federal Government has begun work the proposed sale, issuing a call for tenders from business and accounting experts to undertake a scoping study, to be completed by the end of February.

The Government has set out its objectives for the sale, including that it contribute to a competitive and viable private health insurance sector, that services standards for policyholders be maintained, the employees are treated fairly, that any residual risk and liabilities for the Commonwealth be minimised, and that the sale price be maximised.

Health Minister Peter Dutton said on Sky television that the Government "really doesn't have a business [being] in this [the private health insurance market]".

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Health on the hill

Political news from the nation's capital

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Seeking to allay concerns the privatisation would lead to more costly health insurance, Mr Dutton thought it would actually achieve the opposite.

"I think with the sale we'll see more competition," he said. "I think Medibank Private, particularly given the presence that it has in the market, has an opportunity to introduce more reform efficiency without the monkey of government on its back.

"And I think, ultimately, that will have a positive impact on the way in which premiums are priced and competition operates in the private health insurance market."

But AMA President Dr Steve Hambleton remained cautious about the proposed sale.

"Our main concern was that there may be potential for decreased competition in this industry. If that's the case, that will drive up premiums for everyone," Dr Hambleton said, adding that this is one of the issues that should be addressed by the scoping study.

"We want to understand about whether competition will be decreased, whether there is a risk of premiums, because that'll affect us all," he said. "It's a very fine balance between the public and private sector in this country, and we know that you don't have the capacity in public hospitals if there's a major shift away from the private system."

Dr Hambleton said two possible ways of selling off Medibank Private were to allow acquisition by another domestic health fund, or by an offshore entity, and both outcomes carried with them concerns.

"If it's a trade sale to one of the other players then that decreases the number of players [and] if there are international sales, that may bring in some further risk. So we'd like to see the results of the scoping study."

The Medibank Private Sales Act would have to be amended to remove a 15 per cent ownership limit if there was to be a trade sale, while any purchase by an offshore entity would like be scrutinised by the Foreign Investment Review Board

Adrian Rollins

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Nation gets mixed health report card

AMA President Dr Steve Hambleton has urged an end to the Federal-State blame game over medical funding to ensure further improvements in the nation's health.

Dr Hambleton said better cooperation between the Commonwealth and the states and territories was needed if the country was to build on improvements in life expectancy, preventable hospitalisations and Indigenous health, including by cutting elective surgery waiting times and tackling obesity.

In his five-year report card on national reform, Council of Australian Government Reform Council chair John Brumby said there was a lot that the country was getting right.

"Australians are living longer (we still have one of the highest life expectancies in the world), fewer people are dying from circulatory disease, fewer people are smoking, there are less potentially preventable hospitalisations and our emergency wards are seeing more people in a timely manner," Mr Brumby said, adding that progress was being made in closing the gap between Indigenous child mortality rates and those of the rest of the community.

But the former Victorian Premier also identified areas of concern, including increasing rates of obesity and longer waiting times for elective surgery.

He added that the overall Indigenous mortality rate had barely improved since 2008, and the current rate of improvement was "nowhere near enough to close the gap by 2031".

Dr Hambleton welcomed Mr Brumby's report as a reminder of what had been achieved, and what still needed to be done.

He said the COAG report identified several long term health goals that needed to be tracked.

"It's very good that our life expectancy is continuing to go up, it's also very good that our smoking rates are coming down. We're seeing that preventable hospitalisations are down, that's a good thing.

"We haven't seen, though, the decrease in the waiting times for elective surgery that we'd like to see come out from better cooperation from State and Federal [governments], and we are disturbed to see that obesity rates have gone up, that is a problem.

"So, there's more work to be done. It's good that we're measuring these things, and we've made some improvements. But there's still some areas that we can do better."

Dr Hambleton said the ageing population was increasing the pressure on the nation's hospitals, and funding for beds had not kept pace with the increase in demand.

"So, as well as doing better with what we've got, we actually still need that infrastructure, we still need those beds to treat our public and our population," he said.

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Health on the hill

Political news from the nation's capital

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And he called for a "multi-factorial approach" to tackle the nation's increasing incidence of obesity, including everything from the way cities, suburbs and towns were designed to food labelling and educating children about good nutrition.

"We've got to make sure that we have a population that embraces exercise, and recognises that one hour of exercise every day is really important to maintain our health," Dr Hambleton said. "The message is not getting through. This is not just a health message. Every portfolio needs to think about this so we can all work together to turn this around."

Adrian Rollins

TO COMMENT CLICK HERE

Smokers could pay through the nose for hospital care

The Federal Government is coming under pressure from State Governments states to funnel $5 billion to be raised from a boost in the tobacco excise into the public hospital system.

At a meeting of the nation's Health Ministers on 8 November, Federal Health Minister Peter Dutton confirmed the Abbott Government would proceed with a 12.5 per cent hike in the tobacco excise first announced by the previous Labor Government just before the Federal election was called.

The excise, which will add $5.25 to the cost of 20-pack of cigarettes is expected to raise $5 billion in the next four years, and the states – particularly Victoria - are keen to use the money to defray rising public hospital costs from treating smoking related-illnesses.

In a communique issued following the Standing Council on Health meeting, the Health Ministers "welcomed the announcement by the Federal Government that it will progress the 12.5 per cent increase in tobacco excise over the next four years to respond to smoking-related cancer".

The Victorian Government has been hounding the Federal Coalition Government ever since it was elected to reinstate $1.4 billion that it believes was unfairly withheld from its health funding by the previous Labor Government.

Victorian anxiety has been heightened by the Abbott Government's refusal so far to honour a commitment by former Health Minister Tanya Plibersek to contribute $100 million toward an upgrade of the Royal Victoria Eye and Ear Hospital.

The Victorian Government has also been leading the other states in voicing concern about the cost of treating overseas tourists and other visa holders using the public hospital system.

The Australian reported that in 2011-12, Medicare-ineligible patients failed to pay bills for treatment worth $40 million, including births, elective surgery and treatment for minor ailments.

Access to emergency care is free, but other treatment is not, and one option suggested is to ban from re-entry foreign citizens who have left the country without paying their medical bills.

A spokeswoman for Mr Dutton told The Australian the Minister understood the issue, and would work through it with the states.

Adrian Rollins

TO COMMENT CLICK HERE

Hospitals and health care far from equal

Almost 10 per cent of all hospital admissions are potentially avoidable, and some hospitals are taking up to twice as long as the national average to treat their patients, a national assessment of the health care system has found.

There were more than 635,000 potentially avoidable hospital admissions in 2011-12, which between them chewed up 2.5 million hospital bed days – 9 per cent of all hospital bed days - according to the National Health Performance Authority.

The Authority based its findings on the definition of 21 chronic, acute and vaccine-preventable conditions for which hospitalisation could have been avoided with timely and effective primary and preventive health care - a finding that suggests boosting resources for primary care could go a long way toward relieving pressure on stretched public hospitals.

The report, *Healthy Communities: selected potentially avoidable hospitalisations in 2011-12*, identified significant geographical variations in rates of preventable hospitalisations, particularly in rural and regional areas.

It particular, it found that people living in Tasmania had the lowest rate of potentially preventable hospitalisations (1098 hospitalisations per 100,000 people), while among those living in Victoria's Great South Coast Medicare Local catchment the hospitalisation rate was 2809 per 100,000.

In a separate report, *Hospital performance: length of stay in public hospitals in 2011-12*, the Authority identified similar wide variations in the speed with which hospitals discharged patients.

The study was based on data collected from 125 public hospitals regarding the provision of treatment for 16 different conditions or procedures, including childbirth, cellulitis, heart failure, kidney and urinary tract infections, gall bladder removal and hip and knee replacements.

Adrian Rollins

TO COMMENT CLICK HERE

Research

Removing pulmonary nodules early may save lives

Lung cancer may be curable by removing the pulmonary nodules early in the development of the deadly disease, according to two radiologists.

Dr David Milne from Aukland DHB Radiology and Dr David Midthun from the US Mayo Clinic said that early evidence of pulmonary nodules may be the first and only point in time where there is a chance of a cure in patients with lung cancer.

However, in a note of caution, they said the majority of the pulmonary nodules were benign, and surgery always carried with it risks.

Dr Milne and Midthun presented a review paper at the 15th World Conference on Lung Cancer, which outlined indicators to accurately classify nodules to help determine whether surgery was possible or appropriate.

The processes incorporated images from CT scans and PET scans to inform decisions about the resection or other treatment of lesions and nodules.

The radiologists said there was evidence that the majority of nodules which are currently excised using surgery are actually benign. They estimated that between 50 and 80 per cent of nodules that get removed would have caused no problems.

"Reductions in surgery for benign nodules can be achieved by simply observing smaller nodules, using the latest scanning techniques to classify nodules, and by capturing historical images that help us assess whether or not nodules are getting larger," Dr Milne said.

"It is all about using the latest imaging technology to maximise the prospect of better patient health outcomes, while minimising the risks that come from surgery that is likely to achieve little."

Kirsty Waterford

TO COMMENT CLICK HERE

Melanoma – the key to a cure is in the genes

Slip, slop slap, seek and slide is a sun-safe message familiar to most adults.

But figures show that, despite the warnings and precautions taken while in the sun, around one in 20 Australians will develop melanoma in their lifetime.

Malignant melanoma represents only 2 per cent of all skin cancers in Australia, but it is responsible for almost 80 per cent of skin cancer-related deaths.

Melanoma can rapidly spread via the blood from a primary tumour in the skin to form aggressive secondary tumours throughout the body. The average survival time is less than nine months, and less than 10 per cent of patients survive for five years.

Unfortunately, as Professor Richard Scolyer, Co-Director of Research Melanoma Institute of Australia said, "treatment for melanoma is not a one-size-fits-all solution".

Professor Scolyer and colleagues are involved in a large-scale research initiative analysing tissue from 500 patients with melanoma to identify common gene mutations that cause the cancer. The researchers are hoping the sequencing will lead to more personalised treatment for patients.

Professor Scolyer said the genome sequencing will provide insights into the evolution and progression of melanoma, as well as answers as to why some melanomas spread, or metastasise.

"While advances in treatment have cut mortality rates in many other cancers, melanoma remains resistant to drug therapy, and the prospects for patients with advanced tumours are poor," Professor Scolyer said. "Advanced stage metastatic melanoma is associated with very high mortality and, until very recently, there were no effective systemic therapies."

"The genome sequencing will eventually enable clinicians to select treatments based on an individual patient's specific genomic tumour profile – treatment known as personalised medicine."

Currently more than 200 melanoma tumour-control pairs have been tissue- and DNA quality control-tested, and tumours from more than 100 patients have been sequenced.

Professor Scolyer said the pattern of gene mutation of melanomas varied between people, which is why one melanoma that looks the same as another to a surgeon or pathologist might be more dangerous, and need more aggressive treatment.

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Research

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"The new genome data being sequenced will provide the potential for registered researchers around the world to use this information for specific research projects and develop a whole new set of new diagnostic, prognostic and therapeutic outcomes," Professor Scolyer said.

The project is supported by the Australian and New South Wales governments, Melanoma Institute Australia, Bioplatforms Australia on behalf of the Commonwealth Government and the Cancer Council NSW.

Kirsty Waterford

TO COMMENT CLICK HERE

Chocolate may lower body fat

It is a research finding that is the dream of every chocoholic.

Researchers at a European university claim to have found an association between higher chocolate consumption and lower fat levels.

The study, based on data collected from 1458 youths aged between 12 to 17 years from nine different European countries, found that those who eat a lot of chocolate have lower levels of total and abdominal fat.

The researchers found that those who consumed, on average, 42 grams of chocolate a day – equivalent to one Mars bar – had a lower body mass index and central fat and waist circumference than those who ate only 4.2 grams of chocolate per day.

The associations were made after the elimination of other potential factors included levels of physical activity, fruit and vegetable consumption, saturated fat consumption, gender and energy intake.

Lead researcher Dr Magdalena Cuenca-Garcia, from the University of Granada in Spain, said even though chocolate contains sugar and fat, it was also high in flavonoids, which have "important antioxidant, antithrombotic, anti-inflammatory and antihypertensive effects, and can help prevent ischemic heart disease".

The researchers noted that there was no information on the type of chocolate consumed included in the study. Dark chocolate is known to have an especially high concentration of flavonoids.

The research was part of the Healthy Lifestyle in Europe by Nutrition in Adolescent Cross-Sectional Study.

Kirsty Waterford

TO COMMENT CLICK HERE

Japanese close to diabetes breakthrough

Japanese researchers say they are a step closer to an oral treatment for diabetes, offering hope of a breakthrough against a disease plaguing an increasingly obese world.

Scientists at the University of Tokyo said they have created a compound that helps the body to control glucose in the bloodstream, tackling one of the key risk factors in the development of type 2 diabetes, which can lead to heart disease, stroke and kidney failure.

The increasing prevalence of overweight and obesity in many countries has been linked to a rapid increase in the incidence of type 2 diabetes.

Studies have shown that obese people tend to have lower levels of adiponectin, a hormone that regulates glucose and increases the effectiveness of insulin.

The compound developed by the Japanese researchers, which they have called AdipoRon, imitates the effects of adiponectin, though, unlike the hormone, AdipoRon is not broken down as it passes through the gut.

Toshimasa Yamauchi, a member of the research team and lecturer at the Graduate School of Medicine at the University of Tokyo, said AdipoRon could be a lead compound in a possible oral treatment for diabetes and we aim to launch clinical tests in a few years.

Those with type 2 diabetes are advised to improve their diet and exercise, but the Japanese researchers said that this sometimes proved too much of a challenge.

"Dietary therapy is not easy, even for healthy people, no matter whether or not they are obese or have disease," they said. "The opportunities for exercise have inevitably reduced drastically as society has become more automated."

Sanja Novakovic

TO COMMENT CLICK HERE

Killing someone not as easy as it is made out to be

The execution of Joseph Franklin, a confessed murderer languishing on death row in the American state of Missouri, may not go ahead quite as planned.

But, according to a report in *The Economist*, the glitch has nothing to do with last-minute legal appeals or Supreme Court challenges. Franklin's guilt is not in doubt. has admitted to killing at least 15 blacks and Jews, and claims he was responsible for putting publisher Larry Flynt in a wheelchair.

Instead, the possible delay is being caused by problems getting a drug to inject into Franklin on 20 November, the day he is due to be executed.

Missouri's Department of Corrections had planned to give Franklin a lethal injection of the common anaesthetic Propofol until the drug's manufacturer, the German firm Fresenius Kabi, directed that it must not be used for capital punishment.

In response, the Department obtained an unsanctioned batch of the anaesthetic to use. But it was warned that if Propofol was used for an execution this would trigger European Union sanctions that might have led to shortages of the drug in the State's hospitals, forcing the States to return the drugs.

The State then looked for an alternative and settled on Pentobarbital, but this has also proved to be a problematic choice because its manufacturer bars distribution of the drug to prisons.

The conundrum has led to suggestions that compounding pharmacists be hired to make up batches of drugs that can be used for executions.

But the record of compounding pharmacies in the United States is less than reassuring – in 2006 the Food and Drug Administration found that a third of drugs produced by compounding pharmacies were unusable, and last year contamination of a compound medicine caused a deadly meningitis outbreak in Massachusetts.

Doubts about the purity and efficacy of drugs intended for use in lethal injections could open the way for legal challenges against executions on the grounds that they could violate the constitutional ban on cruel and unusual punishment.

Adrian Rollins

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.

Expert Australian medical team treats thousands hurt by massive typhoon

A crack team of Australian doctors, nurses and support staff have begun treating hundreds of injured Filipinos in a self-contained portable hospital set up in an area of the Philippines left devastated by a massive typhoon.

The medical team was rushed to Tacloban City less than 48 hours after Typhoon Haiyan, one of the most powerful storms ever recorded, left a path of destruction across one of the Philippines' main islands, killing more than 4400 people and leaving up to a million without adequate shelter or safe water supplies.

The 36-member team is experienced in operating in the chaotic aftermath of major natural disasters, and took with it all equipment needed to operate a stand-alone 60-bed hospital, complete with two operating theatres, x-ray facilities, generators, food, water purification systems and medical supplies.

The team, which is drawn from the Northern Territory, Queensland, South Australia and New South Wales, comprises two surgeons, two anaesthetists, four other doctors, 15 nurses, four paramedics, a radiographer, a pharmacist, an environmental health officer and six logistical experts.

The team is expected to have sufficient supplies and equipment to treat around 3500 patients, including 200 operations, by the end of the month.

Its deployment has been coordinated by the Darwin-based National Critical Care and Trauma Response Centre, and Centre head Dr Len Notaras said the team was highly trained and experienced.

"They'll have a sixty bed, fully deployable hospital, which is air conditioned, its own generators, its own power sources, and fuel, and as well as that they'll have their own sleeping quarters, their own food and so on," Dr Notaras told ABC radio.

"It will be a confronting scene but, by the same token, these are highly trained individuals who are well equipped to respond to events such as this and will be, as soon as they touch down, able to provide assistance to the people of the Philippines."

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**.

Mexico taxes soft drinks, junk food as obesity rates go loco

Mexico has imposed a hefty tax on sugary drinks and junk food in an effort to trim the nation's bulging waistline, drawing the attention of public health experts worldwide.

Mexico's Congress has passed a 1 peso-per-litre tax on soft drinks and an 8 per cent levy on fatty foods as the Central American country confronts an obesity crisis that even eclipses that found in the United States.

According to a report by news service Reuters, Mexicans are the world's greatest soft drink consumers, guzzling on average 707 0.24 litre servings per person each year, compared with an average 701 servings in the United States.

The move makes Mexico the first of the world's large soft drink markets to impose such a tax, which has been proposed in several countries grappling with the health effects of high calorie diets.

Last year, soft drink companies mounted a successful legal challenge to block a move by New York City Mayor Michael Bloomberg to impose a ban on the sale of large sugary drinks, while early this year the Cancer Council, Diabetes Australia and the Heart Foundation of Australia jointly called for Government to consider imposing a specific tax on sugary drinks.

The idea has been backed by a group of researchers in the United Kingdom, who claim that a 20 per cent levy on sugary drinks would result in up to 250,000 fewer of obese adults in the country, while adding more than $460 million to Government revenue.

The researchers, whose study was published in the *British Medical Journal,* estimated that a 20 per cent tax on soft drink would cut purchases by around 15 per cent, and by more among price-sensitive younger people.

One of the researchers, Dr Adam Briggs of the British Heart Foundation Health Promotion Research Group, told Sky News: "Sugar sweetened drinks are known to be bad for health, and our research indicates that a 20 per cent tax could result in a meaningful reduction in the number of obese adults in the UK."

"Such a tax is not going to solve obesity by itself, but we have shown it could be an effective public health measure, and should be considered alongside other measures to tackle obesity," Dr Briggs said.

But imposing a tax on sugar in drinks could push manufacturers into looking at alternatives, or encourage consumers to spend more on soft drinks and less on other items, including possibly more healthy food.

In Mexico, there are concerns that major drinks manufacturers such as Coke Fesma will simply substitute cane sugar in their drinks with cheaper, high-fructose corn syrup.

Coke Fesma told the market it would pass the tax onto consumers by increase the cost of its products by between 12 and 15 per cent.

Adrian Rollins

TO COMMENT CLICK HERE

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."

Syrian polio outbreak delivers blow to eradication hopes

The World Health Organisation has declared a polio emergency in the Middle East following an outbreak of the crippling disease in wartorn Syria, warning it is likely to spread through neighbouring countries as millions flee the bloody conflict.

The WHO has confirmed the presence of wild poliovirus type 1 in 10 young children, who were part of cluster of 22 cases of acute flaccid paralysis detected in the country's east.

It is the first appearance of the disease in Syria since 1999, and has accompanied a huge decline in immunisation rates from 81 per cent to 68 per cent since violence erupted more than two years ago.

Syrian health authorities have launched a campaign to vaccinate 1.6 million children against diseases including polio, but efforts to boost immunisation rates are being severely hampered by the country's bloody civil war, which is estimated to have claimed the lives of at least 115,000 people and displaced millions more.

The WHO warned of a high risk that the disease will spread across the region, delivering a big blow to hopes that it was on the verge of being eradicated like smallpox.

"Given the current situation in the Syrian Arab Republic, frequent population movements across the region and subnational immunity gaps in key areas, the risk of further international spread of wild poliovirus type 1 across the region is considered high," the WHO said. "A surveillance alert has been issued for the region to actively search for additional potential cases."

Writing in *The Conversation*, Professor Michael O'Toole of the Burnet Institute said the big surprise about the outbreak is that the point of origin may be Israel.

Professor O'Toole said that since February more than 100 samples of sewage from central and southern Israel, as well as from Gaza and the West Bank, had tested positive to the polio virus.

He said a recent study suggested up to 5 per cent of Bedouin children carried the virus, but because immunisation rates in this community were high, children did not show symptoms of the disease.

But it is highly contagious, and Professor O'Toole speculated that the mobile Bedouin population may be helping spread the disease across countries in the region.

Before the latest outbreak, there were hopes the disease was well on the way to being eradicated.

The number of polio cases worldwide plunged by 99 per cent between 1988, when there were 350,000 infections, and 2012, when just 223 cases were reported worldwide.

But Professor O'Toole said the disease had made a disappointing comeback since then, with 332 cases registered so far this year – an increase of almost 50 per cent from 2012 – including 180 cases in areas of Somalia under the control of Islamic militants Al Shabab, who have banned vaccinations.

He warned that the documented reservoir of the disease in Israel posed a risk for unvaccinated people who visited the area or came into contact with people from the area, including Australian children who had not been vaccinated because of the objections of their parents.

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:

In the 4 November edition of *Australian Medicine*, Australian Medical Students' Association President Ben Veness raised the issue of conscientious objection, and highlighted AMSA's policy, which recognised the right of doctors to exercise their conscience and refuse to provide any non-emergency services to which they conscientiously object. But the policy also stated that exercising a personal objection must not infringe the patient's right to be provided with information about, and access to, all available management options. Many AMA Members shared their opinions on the issue.

You acknowledge the importance of, and AMSA's support for, the right of a doctor to conscientiously object to provide any non-emergency medical treatment, while at the same time stating that there should be an obligation from a patient to a doctor that the objector knows does not object to providing that treatment. However, you do not address the obvious elephant in the room: many conscientious objectors would deem they are facilitating the treatment they object to (say, abortion) if they send a patient to someone who they know will provide it. This is an informal referral, and laws requiring this effectively force the doctor who considers this level of participation in the chain of care to be facilitating it, and (as I would) would still be morally compromised. A law that tells me "we respect your right to conscientiously object, but only to the extent that is convenient to us - we'll interpret what you can actually object to" sidesteps the need for this right to be absolute, otherwise it doesn't really exist at all. Further, from a practical point of view, I think you would find that many conscientious objectors would act in breach of this law by refusing to refer regardless. This would then lead to professional but, more worryingly, legal implications, and a whole lot of de-registered doctors.

Submitted by Tom (not verified)

There would surely be a significant proportion of doctors, many of them well-known, intelligent, reasonable, well-intentioned people, would refuse to refer, and so would be in breach of the legislation. Is it really appropriate to require all members of the profession to do some action when such a significant portion of the profession would have sincere ethical difficulties with taking this action? The argument in favour of this legislation seems to be premised on the idea that if patients are not referred to another doctor who can perform the termination, then they will be unable to find a doctor to perform the termination. But, surely, they can generally just look up another place on Google/Yellow Pages etc.? At the end of the day, isn't this just too much of a contentious issue for there to be legislation mandating certain actions when there is such a widespread variance of views across the profession? By way of comparison, in the legal profession, I doubt there would be any comparable statutory requirement imposed on lawyers in circumstances when such a significant percentage of the legal profession would have sincere ethical difficulties with that requirement.

Submitted by Macca (not verified)

Great discussion. I share in your concerns Tom. It seems the validity of conscientious objection is being questioned. A referral of even an informal kind is still a medical form of management that I would see as partaking in the care of a patient. Interested to hear about the form of discussion that occurred before AMSA took this stand.

Submitted by Sam (not verified)

Chair of AMA Ethics Committee Dr Elizabeth Feeney discussed what doctors needed to consider when a major public health emergency occurred, such as the recent bushfires in NSW. Several AMA members gave their suggestions.

I would like to put in a plug for doctors to contribute to the response to disasters by joining organisations that are able to organize and train responders to disasters. There are many that do this, both in the voluntary and paid spheres. From St John Ambulance to Red Cross and the ADF, to name just a few. The point is that well-meaning but poorly-prepared help is frequently worse than no help at all. So Liz's point about thinking about it well in advance is perhaps the most important. We also have our statutory obligation under the Medical Practitioners Acts, and now AHPRA legislation, to provide care when called upon to do so, but this is unlikely to be invoked except for those caught up in a disaster. The provisions of the Acts do not compel us to provide care at our own peril as I understand it. That is a personal decision, and also strays into my original point. You need to be prepared to provide care in a disaster. It's nothing like anything else you, do unless you undertake out-of-hospital care. Well done Liz for raising this.

Submitted by Finlay Macneil (not verified)

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. One AMA member agrees with the AMA call.

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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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A coordinated plan to facilitate the complete training of our ever-increasing numbers of medical students is urgently needed. I see so many dedicated, motivated and exceptional young medical students who are dedicating their lives to completing a medical degree and becoming a doctor. This looming disaster is something most of them are unaware of, and could create long delays in completing what is already a very long training programme.

Submitted by Dr Bill Johnston (not verified)

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. AMA members share their view.

"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." The response to this is that there is a failure of workforce planning by Queensland Health. Surely, overtime functions as a useful disincentive to overworking individual doctors. The solution, when particular doctors are earning significant overtime on a regular basis, is to respond to the obvious unmet need by employing another specialist. Without overtime, where is the incentive to plan appropriately to meet the clinical need and to ensure safe working hours? How does the AMA ensure that this concern gets shared with the public? The proposed individual contracts are not in SMOs interests, but they are clearly not in the public interest either.

Submitted by Rebecca Wild (not verified)

The day *A Current Affair* invaded my practice: GP recounts damage caused by TV show stunt on medical certificates. Many AMA members expressed their view on the issue.

ACA were very lucky that Dr Chambers himself was not depressed or fragile at the time they chose to publicly humiliate him and trash his professional reputation on national prime-time television in response to his genuine attempt to help a patient presenting as in need of medical care. GPs do, after all, have higher rates of depression and suicide than the general population, and it stuns me that *ACA* apparently never learnt from the experience of their colleagues at 2Day FM (c.f. Jacintha Saldanha) that the deceitful entrapment of one person in order to amuse the many will sooner or later lead to tragedy. Just as well, for all of us, that Dr Chambers is evidently made of strong-enough stuff.

Submitted by John Mahony (not verified)

It is not difficult to deceive a doctor into issuing a sick leave certificate, especially when the purported patient comes prepared to deceive. He can always tell the doctor symptoms he knows will help him get the certificate. This sort of so-called investigative journalism is deplorable because it gives the vulnerable public the wrong impression of how doctors carry out their duties.

Submitted by Leslie Chen (not verified)

The only thing sadder than ACA is the number of people who watch it.

Submitted by b (not verified)

What astounds me is the hypocrisy involved in ACA making the allegation that the GP made fictitious and deceitful declarations when quite clearly their whole story was a factitious and deceitful (public) defamation itself. I would not be surprised if there was a defamation case in this. What a rubbish program, doing nothing but stirring up hate and distrust in society where it never existed, all for ratings!

On a slightly separate but related note, I would warn fellow medical colleagues to be wary of more genuine patients making surreptitious (often audio only) recordings of consultations on their smartphones, and would also ask patients who do this to think about the damage that might be done to a professional relationship if caught. Most doctors will probably consent to being recorded if asked up front, but catching a sneaky recording device will almost certainly sever any trust in a doctor-patient relationship.

Submitted by Tom Forbes (not verified)

As well as legal action for defamation, if a Medicare rebate was claimed as part of this consultation, then that amounts to Medicare fraud by the "patient" (i.e. the ACA producer). I hope the doctors involved notify Medicare of this incident, if this is the case.

Submitted by A Tauro (not verified)

TO COMMENT CLICK HERE

Texting and Driving - "He's gonna kill me!"

BY **DR CLIVE FRASER**

For more than 20 years I've driven to work along the same familiar route.

It's a short drive through non-descript suburbia.

While the surroundings have slowly changed, I've driven that route ten thousand times and I feel like I know it like the back of my hand.

Over the years, the journey to work has become second nature to me, and I'm very aware that familiarity can breed contempt.

While my old Volvo does have a CD (and cassette) player, on my way to work I prefer to listen to ABC radio news and AM.

For 10 years the familiar voice of Tony Eastley has been my sole companion on my daily drive.

Some might say I'm old fashioned, but I just don't like all those distracting bits of technology (MP3s, podcasts, Bluetooth streaming etc) that are very fashionable right now.

So, as I set off for work last week for the ten-thousand-and-first-time and came to a roundabout only 300 metres from where I live, I gave way to a lady in a brand new Hyundai ix35 4WD who seemed to be looking down rather than straight ahead.

Now, most roundabouts have three exits, but the lady driver in front of me decided to make a whole new exit for herself across a traffic island, over a gutter and into a nature reserve.

While she was in a 4WD with presumably some off-road capability, her progress was halted after she came into contact with the park's perimeter defences.

In an effort to stop hoons from driving onto the grass, the local council have placed vertical bollards around the park, and her brand new Hyundai ix35 came to rest impaled on a 60 centimetre-high railway sleeper that had been placed in the ground.

Realizing that the lady might be injured, I hastily pulled over and ran to her aid.

Like most people involved in a crash, she was understandably very distressed.

I found her screaming uncontrollably, "He's going to kill me, he's going to kill me!"

I immediately thought that she might have been on the run from a member of an outlaw motorcycle gang.

We have a lot of that happening in Queensland right now, according to our Premier.

Perhaps that's why she was distracted and ran off the road in perfect driving conditions?

There was a hissing sound coming from the front end of her car.

She wanted to try to start the Hyundai to drive backwards and get on her way.

From what I could see, that wasn't going to be possible.

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Texting and Driving - "He's gonna kill me!"

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I courageously told her that I'd help her out, and my first thought was to open the driver's door.

While the Hyundai ix35 does have a five-star safety rating on ANCAP testing, I regret to say that the door would not open as the front guard had concertinaed backwards.

I heard more hissing from under the bonnet and, believing that an explosion was imminent, I raced to the passenger side and couldn't budge that door either.

As the lady was fairly slim, she climbed into the back and exited through the rear doors.

She fell into my arms, hysterically screaming again, "He's going to kill me, he's going to kill me!"

As a psychiatrist, I hadn't really come across this situation in my training, but by now a rather bosomy neighbour had arrived and the victim fell into her arms still screaming, "He's going to kill me, he's going to kill me!"

It was at that point that the new rescuer's CWA training stepped in, and she said, "Cars can be fixed, I'm just glad you're not injured".

To which our hapless victim kept sobbing while she cried, "He's going to kill me, he's going to kill me!"

By now I was running late for work and Tony Eastley had signed off.

The crash victim had forgotten about her rescuer who holds a Certificate in Advanced Life Support.

There was nothing more that I could do but call a tow truck.

At that point the woman's iPhone fell to the ground and I saw a half-written text message!

She wasn't trying to escape from an outlaw motorcycle gang after all.

She was teeing up a meeting with Jo-Anne for a latte.

It was then that I realized that if I'd been a second earlier on that roundabout, it could well have been me saying "She was going to kill me, she was going to kill me!"

Please don't text while driving.

Hyundai ix35 2.4 Elite AWD	
For	Affordable, roomy family wagon with a five year warranty.
Against	Not able to drive over vertical bollards.
This car would suit	Anyone who doesn't text while driving.
Specifications	4 litre 16 valve 4 cylinder petrol 136 kW power @ 6,000 rpm 240 Nm torque @ 4,000 rpm 6 speed automatic transmission 9.8 l/100 km (combined) $37,390 drive away (Buderim, Qld)
Fast facts	56 per cent of drivers admit to texting while driving. If you text while driving, your risk of crashing increases more than 23 times.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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