AUSTRALIAN
Medicine
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Star turn in obesity battle

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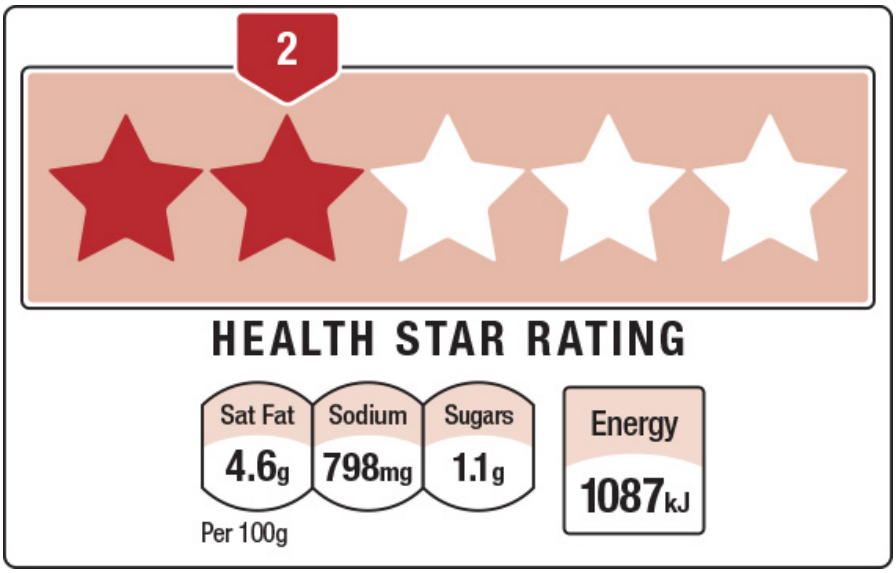
Healthy food choices in the stars



Shoppers will soon be able to use a simple front-of-packet star rating system to quickly gauge how healthy and nutritious food is following trans-Tasman agreement on a new food labelling scheme.

Australia and New Zealand ministers responsible for the regulation of food have approved the introduction of a five-star rating system for food packaging following a key meeting late last week.

Under the Health Star Rating system, food will be assigned an easy-to-read star rating based on a nutrient profiling system developed by Food Standards Australia New Zealand, with food rated from half a star to five stars. The more stars, the greater the nutritional value of the food.

In addition to the stars, the front-of-packet information panel includes details of a food's energy content, as well as how much saturated fat, sugar, sodium and one other positive nutrient (such as calcium or fibre) it contains.

Food packets carrying the star rating and associated information are expected to begin appearing on shop shelves around mid-2014.

Significantly, the ministers have put the food industry on notice that if, after two years, it has not voluntarily adopted the system, the change will be made mandatory.

The AMA and other health groups have hailed the landmark move as an important development in tackling the nation's rapidly growing obesity problem, with indications that more than 60 per cent of adults and 25 per cent of children are overweight or obese.

But food manufacturers have won an important exemption in the system. Soft drinks and confectionary will not receive a star rating, though manufacturers will be required to display energy content.

AMA Vice President Professor Geoffrey Dobb said the decision was a major win for public health.

"The ministers have earned a gold star for backing a labelling system that will make it easier for people to make informed choices about healthy foods," Professor Dobb said.

In a statement following the meeting, Health Minister Tanya Plibersek said the new system was an important step in alleviating the nation's future burden of chronic disease associated with overweight and obesity.

"Today more than four million Australians are obese, and almost 10 million are overweight," Ms Plibersek said. "Overweight translates into chronic diet-related diseases, hospitalisations and a significant rise in long-term care, so this is a significant step in assisting consumers make informed choices."

The move has come amid mounting pressure from the AMA and other health groups to improve food labelling to make it easier and quicker for consumers to assess the nutritional value of products.

Poor food choices are seen as contributing to the nation's mounting weight problem, with the Australian Institute of Health and Welfare estimating that 62 per cent of adults - 12 million people – were overweight or obese in 2007-08, along with one in four children.

The AMA was part of a working group on food packaging that for the past two years has been developing the star labelling system presented to the ministers on Friday.

The group included representatives from the food industry as well as public health and consumer groups.

Professor Dobb said the system, similar to other star rating schemes, would be simple for consumers to understand and use, and was underpinned by sound evidence regarding what works.

"The star rating system is the result of two years of hard work by representatives of government, the food industry, public health groups and consumer groups," he said. "It is based on strong science, proven health advice, market research – and a large dose of common sense."

Professor Dobb said the star system was a "sound step in the right direction" to help families make more informed food choices.

"It is a good compromise that takes into account industry issues as well as health and consumer concerns."

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TO COMMENT CLICK HERE

Department backs down in after-hours bungle

Funding confusion and increasing red tape threaten the availability of after hours GP services, the nation's peak general practice organisation has warned.

United General Practice Australia, which includes representatives from the Australian Medical Association, the Royal Australian College of General Practitioners, the Australian General Practice Network, the Australian Medical Local Alliance and three other organisations, has raised "serious concerns" about the provision of vital after hours services because of uncertainty and confusion about changes to contracting and funding arrangements.

In a unanimous statement issued following a meeting in Canberra last week, UGPA leaders warned that "without urgent action, patient access to quality GP after hours services would be compromised".

"The provision of after hours services is currently hampered by increasing red tape and confusion around the new arrangements," the UGPA statement said. "Furthermore, this may also be a disincentive for practices to remain accredited as providers of high quality care."

Under Government reforms each Medicare Local will, from 1 July, have responsibility to ensure "comprehensive face-to-face after hours services" are available in their region.

To pay for this, each Medicare Local will receive funds redirected from the Practice Incentive Program (After Hours Incentive) scheme, as well as from the GP After Hours grants program, and some new funding.

Under the original plan, Medicare Locals would engage GP practices as sub-contractors to provide after hours care.

But the Department of Health and Ageing was last week forced to change course amid mounting complaints over how such a system would operate, scrapping the insistence that practices be engaged as sub-contractors.

In a communiqué issued on 11 June, the Department said it had "reviewed and re-considered this position in light of concerns emerging from the [Medicare Local] network, and recognises that there are instances where the implications of that stance may be problematic".

Accordingly, it said, organisations and individuals who are only contracted to provide after hours services would not be considered to be subcontractors.

This has meant that terms from the Deed of Funding between the Department and each Medicare Local do not have to be included in contracts with general practices providing after hours services.

AMA Vice President, Professor Geoffrey Dobb, hailed the Department's decision as a victory for common sense.

"These after hours contracts dramatically increase red tape and compliance costs, even though the new arrangements are virtually the same as the old arrangements," Professor Dobb said. "Many practices are simply getting the same funding as they previously received under the Practice Incentives Program administered by Medicare Australia. The extra red tape and onerous conditions contained in the contracts had led many GPs to contact the AMA for assistance."

Professor Dobb said that "significant numbers of practices" that had been providing after hours services had baulked at signing up to the contracts offered by Medicare Locals because of the onerous terms they contained, and urged that they immediately be revised and reissued to reflect the Department's decision.

UGPA said the Department's change of heart was welcome, and called on Medicare Locals to "advise local GPs of the changes quickly to put an end to any confusion around how after hours services will be managed".

Furthermore, it urged the Department to continue with existing after hours funding arrangements through to the end of the year to smooth the transition to the new contract system.

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Doubts linger over FBT liability for education expenses

Doubts linger over whether employers will be liable for fringe benefits tax when they spend more than $2000 on staff education, despite Federal Government assurances that that is not their intention.

Alarm has been raised that employers will be caught up in the controversial cap on tax deductions for self-education expenses because of a clause buried in a Government Discussion Paper on the tax change.

In part, the clause said the "deductible rule may no longer apply to education expenses in excess of the $2000 cap. This may result in employers being liable for FBT (fringe benefits tax) on any education expenses over the cap of $2000, incurred by them on behalf of their employees".

But officials from the office of Treasurer Wayne Swan have contacted the AMA to provide assurances that it is not the Government's intention to apply FBT to employer payments for staff education expenses, and that the confusion had been created by poor drafting in the Discussion Paper.

But the AMA's concerns about the implications of the clause remain until the Government's assurances are made in writing.

AMA Vice President Professor Geoffrey Dobb said the clause, hidden deep within the Discussion Paper, suggested the tax change went much further than the Government had so far admitted.

"It is a tax on learning," Professor Dobb said. "It would add enormous cost and complexity to ongoing medical education, and many doctors will be forced to limit or scrap further education as their employers opt out of supporting this activity."

AMA President Dr Steve Hambleton said the Discussion Paper, *Reform to deductions for education expenses*, which was posted on the Treasury website late on Friday 31 May, was part of stalling tactics being used by the Gillard Government in an attempt to blunt criticism of the $2000 tax deduction cap ahead of the federal election.

Dr Hambleton told Health Minister Tanya Plibersek during a meeting earlier this month that doctors would not be silenced on the tax change, which he warned would affect the quality of medical education and practice.

He vowed that the AMA would ensure the voice of doctors was heard.

"The AMA and the medical profession will not stay quiet on a matter that affects the quality of medical education and medical practice in this country," the AMA President said.

Dr Hambleton said the Discussion Paper did not define what constituted legitimate professional education expenses for the purposes of tax deductions.

"The Paper is all about targeting what the Government considers non-legitimate expenditure," he said. "There is no attempt to acknowledge the high cost and complexity – or the social benefit – of medical education that allows doctors to keep up with the latest technology, surgical techniques, treatments or medicines."

According to the Paper, almost 640,000 taxpayers claimed a tax deduction for work-related education expenses in 2010-11, with the vast majority (87 per cent) earning a taxable income of less than $80,000 a year.

The median deduction claimed was $905, though among those earning more than $180,000 a year, it was around $2000.

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Doubts linger over FBT liability for education expenses

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The Government has argued that although it is legitimate to claim some tax relief for education expenses incurred for work purposes, it should be recognised that people also derive significant private benefit from such activity.

Ms Plibersek told last month's AMA National Conference the tax change was "not about getting people who have genuine costs for self-education. It's about the first class airfares and plush hotels."

The Discussion Paper used slightly less inflammatory language to make essentially the same argument.

"In some cases, current arrangements allow people to enjoy significant private benefits," the Paper said. "For example, attendance at an overseas conference with a short holiday on the side could make an overseas airfare fully deductible, if the primary purpose of the trip was to attend the conference."

Dr Hambleton said the way the Government had framed the case for the change was not only offensive, but wildly inaccurate.

He said the Discussion Paper made it clear that the full gamut of education-related expenses would count toward the $2000 cap, including tuition and registration fees, textbooks, journals, computers, student union fees, accommodation, running expenses and travel.

"If membership of a professional association includes an educational component, and many do, this cost will also be included in the cap, which makes the reform even worse than originally thought.

"It will take no time at all for doctors and other professionals to reach the $2000 cap," the AMA President said.

The only deductions for expenses not included in the cap would be the non-CPD component of professional membership fees, overtime meal expenses, travel costs not related to education activities, home office expenses, professional indemnity and income protection insurance and clothing and uniform expenses.

"If membership of a professional association includes an educational component, and many do, this cost will also be included in the cap, which makes the reform even worse than originally thought"

The Government has put up for consultation whether there should be a $250 no-claim threshold, which for many would effectively mean the cap was $1750.

It said that abolishing the threshold would cost the Budget $11 million a year, which is dwarfed by the $520 million the cap is expected to save the Government in its first three years of operation.

The cap has also been framed to prevent 'back door' deductions for education expenses through salary packaging. The Government said changes had been made to Fringe Benefits Tax law to ensure employers were liable for FBT on payments made toward the education costs of an employee – though they will still be able to claim a deduction for their expense.

"With the introduction of the cap and associated changes to the FBT law, the employer will be liable to pay FBT," the Discussion Paper said. "The employer will, however, continue to be able to claim a deduction for their expense."

There has been widespread outrage within the medical profession about the change, due to come into effect on 1 July 2014.

More than 4200 concerned practitioners have contacted the AMA to express their anger at the tax change, with 98 per cent warning it would seriously impair their professional development and potentially undermine the quality of care they could provide for their patients.

An AMA poll of 585 doctors found that more than 92 per cent spent in excess of $2000 a year on self-education.

Dr Hambleton said the change was "just plain bad policy".

"The only possible outcome is that doctors will choose not to pursue as much self-education as they do now, if at all, and the ultimate losers will be patients [and] the health system," he said.

The AMA President warned that the education sector would also be a casualty of the change, because it would cut demand for training courses.

He said that, ultimately, all would pay for the change.

"This ill-informed proposal will downskill the professions and reduce productivity in the economy," Dr Hambleton said. "It is just plain bad economic policy to inhibit the ability of people to improve their skills and knowledge."

The Government has promised that Treasury officials will meet with the AMA and other professional organisations as part of consultations on the introduction of the cap.

Submissions on the Discussion Paper close on 12 July.

It can be viewed at http://www.treasury.gov.au/ConsultationsandReviews/Submissions/2013/self-education-expense

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Short-sighted care guidelines overlook best eye care

The Optometry Board of Australia has been slammed over new rules that give optometrists the green light to treat glaucoma and other serious eye conditions without consulting ophthalmologists.

AMA President Dr Steve Hambleton has launched a scathing attack on the Board, accusing it of being "out of step" with expert opinion on how to best care for patients with glaucoma.

"In making these guidelines, the Optometry Board has failed to protect the interests of the Australian public in the detection and proper management of glaucoma and other serious eye conditions," Dr Hambleton said. "The Board is out of step with the experts on best patient care."

The attack came after the Board released updated *Guidelines for use of scheduled medicines* (http://www.optometryboard.gov.au/Policies-Codes-Guidelines.aspx) which expand the scope of optometrist practice, including allowing them to begin treating suspected cases of glaucoma without first consulting with an ophthalmologist, and giving them authority to prescribe and administer Schedule 4 medicines that have potentially serious side effects.

Where glaucoma is diagnosed, or a patient is assessed as being at high risk of developing the disease, the guidelines give optometrists the option of "developing a management plan that includes initiation of treatment and monitoring of the patient's response".

Optometrists are advised that they must consider the referral of a case to an ophthalmologist only if anti-glaucoma treatment does not stabilise the condition.

Dr Hambleton said the proposal was at odds with best medical advice.

"National Health and Medical Research Council guidelines provide for optometrists to seek advice from ophthalmologists where the degree of diagnostic suspicion of glaucoma is high," he said.

"The Pharmaceutical Benefits Advisory Committee recognises the importance of optometrists confirming diagnoses of glaucoma with ophthalmologists and the need for the two health professions to work together to manage patients with glaucoma.

"The peak advocacy group, Glaucoma Australia, wants the previous collaborative care arrangements between optometrists and ophthalmologists for the detection and management of glaucoma to be maintained."

Not only do the guidelines give optometrists the scope to initiate treatment for serious eye conditions without seeking ophthalmological advice first, they also confer on them the ability to prescribe and administer subsidised medicines that have the potential to cause considerable patient harm.

These include anti-glaucoma beta-blocker medications such as Timolol, as well as topical steroids, anti-microbials, mydriatics, miotics and cycloplegics.

Potential systemic side-effects associated with then use of such drugs include bronchospasm, heart block, bradycardia, hypotension, masked hypoglycaemia, impotence, fatigue, depression, fainting and alopecia – none of which, Dr Hambleton said, an optometrist would be expected to know anything about.

The AMA President warned that giving optometrists permission to prescribe and administer such drugs stood at

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Short-sighted care guidelines overlook best eye care

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odds with the approach taken under the Pharmaceutical Benefits Scheme, where "patients with glaucoma can only have access to subsidised glaucoma medicines if the diagnosis is confirmed by an ophthalmologist and there is ongoing collaboration between the optometrist and ophthalmologist".

In a further extension of the scope of practice, optometrists are advised that for serious conditions such as ocular inflammation they may treat emergencies themselves rather than having to refer a case to an ophthalmologist.

"The Board only requires optometrists to consider referral for a specialist opinion for patients who may require long-term steroid use," the AMA President said.

In its advice to optometrists, the Board appears agnostic as the extent to which they should collaborate with practitioners from other specialties, observing that "for eye conditions, shared care is likely to vary according to the location of the patients and the skill-base of local health care practitioners".

In its guidelines, it focuses on how collaborative care arrangements should operate, rather than if and when they should exist.

The Board has indicated that it will monitor the operation of the guidelines, and subject them to review "at least every three years".

But Dr Hambleton said that if the Board does not listen to the medical profession's concerns abut the guidelines, the nation's Health Ministers should take charge and force a re-write.

"If the Optometry Board does not heed the advice of other health professionals who treat eye disease and revoke the new guidelines, the AMA believes that Health Ministers should instruct the Board to do so, in the best interests of patients," he said.

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TO COMMENT CLICK HERE

Transmitter link to soldier cancer must be investigated: AMA

AMA President Dr Steve Hambleton has called for an investigation into a potential link between high-tech equipment used to help protect soldiers from explosive devices and cancer.

The issue has emerged following the death of former soldier Kevin Dillon, who succumbed to cancer at just 28 years of age.

During patrols in Afghanistan, Mr Dillon was tasked with carrying a powerful transmitter intended to block or scramble signals that may be used to remotely trigger hidden bombs.

His mother and sister have asked for an investigation into possible links between the device and the cancer that killed their son and brother.

"I remember Kev saying that, when he came home, he had, like, three of his other friends who had contracted some sort of cancer, or exact same cancer as well," Mr Dillon's sister, Lara Raymond, told Channel 10. "I just want there to be an investigation into this device that could potentially have killed my brother."

Dr Hambleton backed the call, arguing that the health of soldiers who carried the transmitters should be tracked.

He said the device was "quite a strong transmitter" that emitted radiation similar to that from mobile phones, and its potential health effects should be investigated.

"So far there is one soldier, [but] many soldiers are worried, so we do need to make sure they are followed up," the AMA President said. "We have seen cancer clusters before. We need to actually understand, is this a chance finding; is this a non-chance funding?"

"We therefore are saying an investigation should take place, so individual service records are correlated against future illness."

This is not the first time health concerns have been raised about the health of veterans following exposure to chemicals or equipment during service in the armed forces.

The exposure of soldiers during the Vietnam War to herbicides and pesticides, including Agent Orange, has been linked by studies to chronic lymphocytic leukaemia, soft-tissue sarcoma, non-Hodgkin's lymphoma, Hodgkin's disease, and chloracne.

And in 2010-11 the Commonwealth awarded $55 million compensation to air force personnel harmed by fumes while working on and in F-111 fuel tanks between 1973 and 2000.

Dr Hambleton said the concerns of soldiers and their families regarding the safety of transmitter devices deserved to be investigated.

"Serving soldiers who are, again, putting their lives on the line, it's very important that we take them seriously," the AMA President said.

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

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Med school plans lashed amid united call for more internships

Medical groups have condemned controversial proposals for the establishment of two new medical schools as irresponsible given unresolved concerns about a looming shortage of internships in coming years.

Charles Sturt University and La Trobe University have launched a joint bid for $46 million from the Federal Government to help fund a rural medical school operating three campuses across rural New South Wales and Victoria.

The proposal calls for the establishment of the Murray-Darling Medical School, which would operate from CSU's Orange and Wagga Wagga campuses, as well as La Trobe University's Bendigo campus, with an initial complement of 120 training places when it opens in 2015, rising to 180 positions by 2017.

But the plans, and a similar proposal by Western Australia's Curtin University, have fallen foul of medical groups concerned that governments are struggling to provide sufficient internships for medical graduates from existing medical schools, let alone meeting the extra demand created by more medical schools.

Last year, only a last-minute political deal between the Commonwealth and several State and Territory governments averted a disastrous shortfall in the number of internships offered to medical graduates.

There are mounting fears that, with the number of medical graduates set to build every year, the placement crisis will become progressively worse unless there is a clear commitment by the nation's governments to resolve the issue.

Health Workforce Australia estimates that the nation's universities will be producing almost 4000 medical graduates every year by 2016, and has warned that the number of intern places was not growing quickly enough to meet expected demand.

In a report released late last year, HWA said that unless there was significant investment in extra prevocational and vocational training places, the nation faced an annual shortage of 451 specialist training positions by 2016.

Chair of the AMA Council of Doctors in Training (AMACDT) Dr Will Milford said it would be "criminal" if governments allowed a repeat of last year's near-disastrous events.

"It would be criminal of we learnt nothing from the chaos and confusion of last year's internship crisis, and patients miss out on the quality medical care they desperately need," Dr Milford said. "Governments have a responsibility to ensure that all medical graduates can access an internship to complete their training and become registered as independent medical practitioners."

AMACDT has convened a coalition of peak medical student and junior doctor groups comprising the Australian Medical Students' Association (AMSA), Medical Student Action on Training, the General Practice Students Network and the National Rural Health Students' Network, to jointly campaign for a boost in medical internships.

Dr Milford said the coalition would work together to convince all governments to fund their share of internships.

AMSA President Ben Veness said that in such a situation it made no sense to be opening more medical schools.

"Increasing the number of medical students at a time when we are already short of training positions is irresponsible," Mr Veness said. "No new medical schools should be opened without a guaranteed commensurate increase in the number of internships and subsequent training positions."

In addition, he said, there were already accredited medical schools in each of the towns where the proposed Murray-Darling Medical School would have a campus.

Health Minister Tanya Plibersek said recently that resolving the internship crisis and ensuring there were adequate

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Med school plans lashed amid united call for more internships

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places in future was a priority for the Government, and she has written to the AMA assuring it that she will not approve any new medical schools until the current problems are resolved.

A report in *The Australian* suggested Opposition leader Tony Abbott had given a similar assurance to medical school deans.

But National MPs have thrown their support behind the joint CUS-La Trobe University plan.

Regional education spokeswoman Senator Fiona Nash told *The Australian* said the proposal was cost-effective and reflected international experience about effective rural training.

"In my view it deserves the Government's strong consideration," Senator Nash told *The Australian.*

CSU Vice Chancellor Andrew Vann told *The Australian* that current medical schools were producing too many city-based specialists, and not enough practitioners who stayed in regional areas.

He said that too often students trained in regional settings returned to their social networks in the cities, and the CSU-La Trobe University plan provided a "new solution" to the problem.

While the universities are pushing ahead with their proposal, Ms Plibersek told the AMA National Conference late last month that she had ordered work to begin immediately on an "end-to-end rural pathway" for medical students, which was one of the recommendations of the *Mason Review of Australian Government Health Workforce Programs.*

AMA President Dr Steve Hambleton said the pathway had the potential to improve the recruitment and retention of medical graduates in rural areas, as well as expanding critical medical training opportunities in these regions.

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No time to slacken in closing health gap

The AMA has urged all State and Territory governments to renew their long-term commitment to improving Indigenous health amid evidence that significant gains have been made.

The COAG Reform Council has reported good progress in key areas, including reducing Indigenous child death rates, boosting early childhood education and increasing school enrolments.

According to the Council, the nation is on track to halve the gap in child death rates between the Indigenous and non-Indigenous communities by 2018, and is close to achieving the target to have 95 per cent of Indigenous children enrolled in preschool.

AMA President Dr Stave Hambleton said this was heartening evidence of progress, and governments should not squander it by faltering in their effort.

"We need to keep this momentum going and build on it, but it can only happen with long-term funding and political commitment from all our governments," Dr Hambleton said.

The current five-year, $1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes is about to expire and so far only the Commonwealth and the Victorian Government have committed funds to a new five-year deal.

Dr Hambleton said it was vital that the remaining State and Territory governments sign up because, despite promising improvements in some measures, there was still much that had to be done to reduce Indigenous disadvantage.

The COAG Reform Council reported the gap between Indigenous and non-Indigenous child death rates had shrunk from 139 deaths per 100,000 to 109.9 per 100,000 between 1998 and 2011, 91 per cent of Indigenous children were enrolled in preschool in 2011 and in the same year the proportion attaining year 12 or its equivalent was almost 54 per cent – a 7 percentage point increase in five years.

But, against the gains, the Council identified a number of areas that continued to be of concern.

It found that although there was some improvement in the reading ability of Indigenous children between 2008 and last year, they fell behind in numeracy compared with the rest of the population.

In addition, the Council reported that there was little evidence of progress in reducing Indigenous death rates, with Aboriginal and Torres Strait Islander peoples continuing to die at around twice the rate as the rest of the community.

And employment prospects for Indigenous continued to lag well behind those of the broader population, with only NSW reporting progress in narrowing the employment gap between 2006 and 2011.

Dr Hambleton said the report showed that progress can be made "with the right support and commitment", and much more needed to be done.

"We urge the remaining governments to make a funding commitment that is at least the same as the current partnership agreement," he said.

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Tough labour for changes to doctor-midwife collaboration

The Federal Government has committed to organise a summit on collaboration between doctors and midwives following AMA concerns about current proposals for collaborative care.

In discussions earlier this month, Health Minister Tanya Plibersek gave AMA President Dr Steve Hambleton an undertaking to organise a meeting of medical and midwifery groups after he voiced concerns that the changes currently being pursued by the Government would not achieve meaningful collaboration between doctors and midwives.

Last year the nation's health ministers, meeting as the Standing Council on Health, unexpectedly agreed to change the basis for collaborative care arrangements between midwives and hospital and health services.

At the time, Dr Hambleton warned that the proposed change was dangerous and would essentially allow independent practice by a midwife.

The AMA President said that existing arrangements had been carefully devised and agreed upon between the relevant health professional groups, in the best interests of patient safety and team-based coordinated care.

"Under the current process, the private arrangements mirror those in the public hospital sector, where the entire medical, nursing and midwifery team works together and understands the roles and responsibilities for maternity care," Dr Hambleton said at the time.

"The current arrangements already allow for midwives to have collaborative arrangements with a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.

"If the Commonwealth proceeds with [the] decision, it will be essentially allowing independent practice by a midwife."

But, following his meeting with Ms Plibersek earlier this month, Dr Hambleton appeared more optimistic that collaborative arrangements that enhanced patient care could be agreed upon.

At the meeting with the Minister, he emphasised that the proposal as currently devised would not guarantee meaningful collaboration between doctors and midwives, and urged that a meeting of medical and midwifery groups be convened to "try and reach agreement on appropriate guidelines for consultation, referral and transfer".

Ms Plibersek gave an undertaking to organise such a meeting.

In 2009, the then Health Minister, Nicola Roxon, assured the Senate Community Affairs Committee that the current collaborative care arrangements would not preclude collaborative arrangements with a hospital, as long as there was a nominated medical practitioner involved.

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AMA's health message on the national stage

The changes urgently needed to ensure Australians continue to receive affordable access to high quality medical care will be detailed by AMA President Dr Steve Hambleton in a pre-election address to the National Press Club next month.

While health is not expected to be a major political background in the lead-up to the 14 September poll, Dr Hambleton will use his 17 July speech to an influential national audience including leading journalists and federal politicians to help ensure health priorities are not overlooked.

In a powerful address to the AMA National Conference in Sydney last month, Dr Hambleton gave full vent to frustration with Budget cuts to health spending and allowances that he warned would "wreak havoc on Australian families".

In a foretaste of how the AMA will pursue the health agenda during the federal election campaign, the AMA President said the Budget cuts and other recent changes to health policy would push more of the cost of health care onto families and increasingly drive patients towards "an already stressed public hospital sector".

The core messages from the speech, particularly the need to protect the health of the chronically ill, the elderly, young families, accident and trauma victims and war veterans, are expected to be at the heart of the AMA's *Key Health Issues for the Federal Election 2013* document to be released by Dr Hambleton at the Press Club.

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Queen's Birthday honours

Chief Medical Officer Professor Chris Baggoley headed a roll call of distinguished medical practitioners recognised for their outstanding contribution to quality health care in the Queens Birthday Honours List.

Professor Baggoley was appointed an Officer of the Order of Australia (AO) for services to medicine, particularly his work as an emergency medicine clinician and his contribution to public health and medical administration.

AMA members were also prominent award recipients, and AMA Vice President Professor Geoffrey Dobb said the Association was enormously proud of the achievement of each of the 13 members who were honoured.

"These dedicated professionals work many years to gain their specialised skills and expertise, then spend even more years working to save lives and improve the quality of life for many Australians," Professor Dobb said. "Some work in the cities, some work in small country towns, some work in research, some in hospitals, some in private practice, and others in administration – but they all work tirelessly to improve the health of the Australian population."

The AMA members who received Queen's Birthday honours were:

Associate Professor John Clark McBain - AMA Victoria – AO*

For distinguished service to reproductive medicine as a gynaecologist, particularly in the area of infertility, to medical education as an academic, and to professional organisations.

Dr Paul Ernest Beaumont - AMA New South Wales – AM**

For significant service to medicine, particularly in the field of ophthalmology.

Professor Nikolai Bogduk - AMA New South Wales – AM

For significant service to medical research and education, particularly in the specialties of anatomy, spinal health and chronic pain management.

Dr Eric Charles Fairbank - AMA Victoria- AM

For significant service to palliative care medicine in regional Victoria.

Dr John Meredith Harrison - AMA New South Wales - AM

For significant service to orthopaedic medicine, and to water polo.

Dr Francis Xavier Moloney - AMA New South Wales - AM

For significant service to medicine, particularly in the field of anaesthesia.

Winthrop Professor John Phillips Newnham – AMA Western Australia – AM

For significant service to medicine in the field of obstetrics.

Dr John Graham Rogers - AMA Victoria - AM

For significant service to medicine in the fields of clinical genetics and paediatrics.

Dr Peter Harold Woodruff - AMA Queensland - AM

For significant service to medicine, particularly in the field of vascular surgery, and through contributions to healthcare standards.

Dr Jennifer Margaret Wray - AMA New South Wales - AM

For significant service to medicine in rural areas, particularly in the community of Narooma.

Professor Peter Adrian Leggat – AMA Queensland - AM

For significant service to medicine as a specialist in the fields of tropical and travel medicine.

Dr Ronald Dalkeith Scott - AMA New South Wales – OAM***

For service to the community of Boorowa as a general practitioner

Dr Brian James White - AMA Australian Capital Territory – OAM

For service to medicine in the field of mental health, and to veterans and their families.

* Officer of the Order of Australia (AO)
** Member of the Order of Australia (AM)
*** Medal of the Order of Australia (OAM)

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AMA IN THE NEWS

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

Print/Online

GP super-clinics are a super flop, *Adelaide Advertiser*, 6 June 2013

AMA President Dr Steve Hambleton said any further spending on the $600 million GP Super Clinics program should be scrapped.

Alcohol spilling into young minds, *Courier Mail,* 8 May 2013

AMA President Dr Steve Hambleton voiced concern that alcohol marketers were targeting children and encouraging them to become the next generation of drinkers.

Enquiry to focus on coal dust pollution, *Courier Mail,* 10 June 2013

The AMA called for better monitoring, compliance and exposure targets to strengthen air pollutant regulations.

Ad too much: poor-taste list shames alcohol marketing, *The Sydney Morning Herald*, 12 June 2013

The AMA said self regulation by the alcohol industry had failed, and its marketing had to be curbed.

$1m fighting fund to defeat hidden agony, *West Australian*, 13 June 2013

The AMA has backed a $12 million fund established by businessman Geoff Churack to pay for chronic pain research and education. The money will fund an internationally recognised pain specialist to help prepare future doctors to diagnose and treat cases of chronic pain.

Radio

Dr Hambleton, ABC NewsRadio, 06 June 2013

AMA President Dr Steve Hambleton discussed the outbreak of Legionella bacteria in the water supply of a Queensland hospital.

Dr Hambleton, 774 ABC Melbourne, 12 June 2013

AMA President Dr Steve Hambleton revealed he was going to Toronto, Canada, to discuss global health issues, which include a decline in GP numbers.

Television

Dr Hambleton, Ten Late News, Channel 10, 6 June 2013

AMA President Dr Steve Hambleton discussed Queensland Health's response to the Legionnaires disease outbreak at Brisbane's Wesley Private Hospital.

Dr Hambleton, Ten News at 5pm, Channel 10, 10 June 2013

The Australian Medical Association backed calls for an investigation into military equipment used in Afghanistan, following concerns that at least one solider using a transmitting device subsequently developed cancer. AMA President Dr Steve Hambleton said there should be an investigation to identify who has used the transmitters, and to track how their health develops following exposure.

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

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AMA in action

AMA President Dr Steve Hambleton with Shadow Minister for Ageing and Mental Health Senator Concetta Fierravanti-Wells

AMA President Dr Steve Hambleton has spent much of his time since the AMA National Conference in Canberra, meeting with senior politicians to make sure the concerns of AMA members are being heard and understood at the highest levels of Government and the Opposition. In a busy round of meetings, Dr Hambleton held discussions with Health Minister Tanya Plibersek, Shadow Minister for Ageing and Mental Health Senator Concetta Fierravanti-Wells, Shadow Parliamentary Secretary for Primary Health Care Dr Andrew Southcott and Nationals health spokesman Mark Coulton. Dr Hambleton also made a speech at the Australian Medical Students' Association National Leadership Development Seminar, in which he spoke of the importance of leadership within the medical profession. On a brief trip to Sydney, Dr Hambleton took his advocacy for the AMA to the national airwaves, participating in a panel interview with radio announcer Alan Jones and commentator Graeme Richardson on Sky television. AMA Victorian President Dr Stephen Parnis represented the AMA at the launch of the first annual report of the independent Alcohol Advertising Review Board with Professor Mike Daube.

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AMA President Dr Steve Hambleton speaking at the AMSA National Leadership Development Seminar

Dr Hambleton talking with Alan Jones and Graeme Richardson on Sky News

AMA in action

AMA President Dr Steve Hambleton with Shadow Parliamentary Secretary for Primary Health Care Dr Andrew Southcott

AMA Victoria President Dr Stephen Parnis with Professor Mike Daube at the launch of the the first annual report of the independent Alcohol Advertising Review Board

Dr Hambleton with Health Minister Tanya Plibersek

Dr Hambleton with Nationals Health spokesman Mark Coulton

Lost message another e-health hurdle for doctors

Earlier this month the practice of Sydney GP Dr Robert Lewin became one of the first in the country to be commissioned for secure message delivery – meeting one of the key requirements to be eligible for e-health practice incentive payments (ePIP).

But it could easily not have happened.

When Dr Lewin's practice was last month given departmental approval to receive the $25,000 ePIP incentive payment, he naturally assumed that he had satisfied all five of the eligibility criteria set by the Government.

It wasn't until three weeks ago, when his software supplier HealthLink got in touch about commissioning secure message delivery (SMD) that he realised there was more he had to do make sure he was ePIP eligible.

"When I got the call from HealthLink, I thought it was just something that they needed to do as part of their compliance work," Dr Lewin told *Australian Medicine*. "It was only when they provided me with processing documentation for things I would have to do that I became aware that there was more I had to do. I thought I had ticked every box."

There is concern that Dr Lewin's experience is far from isolated, and that many doctors and practices are unaware of the looming 1 August deadline for installing and configuring an SMD system if they want to remain eligible for ePIP payments.

Dr Lewin said the process itself was quick and simple as long as an outside supplier was used to handle the technical aspects of installation.

But the fact that he only found out about it by chance is illustrative of concerns that e-health requirements, including the Personally Controlled Electronic Health Record (PCEHR) system, are complicated and are being introduced in a haphazard way, with little practical support and information for doctors and practices.

The AMA has reiterated calls for the immediate establishment of a clinical advisory group to oversee and advise the Government on the implementation of the PCEHR and its use in clinical practice.

The Commonwealth has allocated $50 million to Medicare Locals to support practices gearing up for the PCEHR, but there is little detail on the specific services Medicare Locals are providing to local medical practices.

Medicare Locals are free to make their own decisions about whether they offer support, and the type of support provided.

But the AMA has been unable to obtain a comprehensive list of the specific support being provided by Medicare Locals to local medical practices.

According to the AMA, this in effect has meant that there is no standard service offered across the Medicare Local network to assist medical practices in rolling out the national e-health program – a situation the Association said was not good enough.

"If Medicare Locals are funded to provide implementation support, they should be contacting and physically visiting all the practices in their catchments to ensure actual PCEHR readiness and capacity," the AMA said.

Dr Lewin said his experience with his Medicare Local, Inner West Sydney, had been "excellent", with the IT staff particularly attentive.

But he shared concerns that practitioners should have been much more closely involved in the design and development of the PCEHR.

Dr Lewin said the template format of the PCEHR meant that creating shared health summaries for patients was relatively quick and straightforward if a practice maintained good medical records with clean data.

But he said aspects of the system were clumsy and, in some instances, dangerous.

A particular concern, Dr Lewin said, was the fact that the system did not automatically direct viewers to the most up-to-date version of a health record, meaning crucial updates such as changes to medication or notations on allergies may not be displayed when a practitioner calls up a record.

He was also concerned that the PCEHR was so far largely a GP-only system, robbing it of much of its purpose.

"It doesn't have a lot of day-to-day usefulness because the only people that are writing to it are GPs," Dr Lewin said.

This is borne out by Government figures, which show that, of the 3039 health care organisations registered to participate in the PCEHR by 23 May, 90 per cent were general practices and 6 per cent were pharmacies.

All up, according to the Department of Human Services, by mid-May 3712 practices had been approved for the revised ePIP incentive – 81 per cent of those that had qualified for the previous ePIP payment.

The Government appears to have intensified its efforts to register people for the PCEHR system.

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Lost message another e-health hurdle for doctors

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Department of Health and Ageing Deputy Secretary Rosemary Huxtable told a Senate hearing early this month that the number of registrations had reached around 250,000, and were increasing by around 10,000 a day – though she admitted the target of 500,000 registrations by 30 June "may be a stretch".

But the AMA is concerned that the rush to sign up people to the system first without adequate support for practices to do the same could lead to frustration and disappointment for patients and doctors alike when one has an e-health record but the other is not equipped to use it.

Dr Lewin said that, in his experience, only a "very negligible" number of patients came to him already equipped with a PCEHR, and most registrations were done during consultations – a process he said was useful for discussing issues such as becoming an organ donor.

The AMA has prepared a checklist to help doctors and practices prepare for the PCEHR and ensure their continued eligibility for ePIP payments.

It can be viewed at: https://ama.com.au/getting-ready-pip-ehealth-incentive-and-pcehr

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Companies can't own human genes: US court

Hopes that life-saving genetic tests will become cheaper and easier to access have been boosted by a landmark ruling of the United States Supreme Court.

In a judgement seen to have far-reaching implications, the Court last week ruled that human genes cannot be patented.

In a unanimous decision, the Supreme Court quashed patents on genes linked to breast and ovarian cancer (known as BRCA1 and BRCA2) held by Utah-based company Myriad Genetics.

Focus on the case intensified last month when actor Angelina Jolie revealed that she had had a double mastectomy after genetic testing confirmed she carried the genes and was at high risk of developing breast cancer.

For the past 19 years Myriad Genetics has held a monopoly as the sole commercial provider of testing services for BRCA1 and BRCA2 in the United States, pushing the cost of testing out of the reach of millions of women.

The case challenging Myriad's patent was launched four years ago by the American Civil Liberties Union and the Public Patent Foundation, and was subsequently joined by groups representing 150,000 geneticists, pathologists, and laboratory professionals.

Myriad's monopoly is also under legal challenge in Australia where, according to the Royal College of Pathologists of Australasia, it has compromised the quality of, and access to, diagnostic genetic tests.

While the US Supreme Court's decision has no legal standing in Australia, it is expected to be taken into account by the Full Bench of the Federal Court when it rules on an appeal against a Federal Court decision in February that upheld a Myriad patent on human genes. The Full Bench is expected to hand down its decision in August.

Chairman of the Genetics Advisory Committee for the Royal College of Pathologists of Australasia, Professor Graeme Suthers, said the timing of the US Supreme Court judgement was significant for the Australian case.

"The timing is great, in the sense that this decision will be available to the Full Bench of the Federal Court," Professor Suthers said.

He said the Supreme Court's decision carried significant weight because it was a rare unanimous judgement, and was the second time in nine months that the top US court had overturned the decisions of lower courts on the patenting of human genes.

The judgement has been met by claims it could cripple the biotechnology industry by undermining revenue base don gene patents.

By Professor Suthers said such concerns were completely overblown, and the Supreme Court had made it clear that its decision applied only to naturally occurring genes, and genes that were synthesised, manufactured or otherwise changed could be patented.

"The Supreme Court has made it clear that DNA sequences that have been altered are eminently patentable, and patents remain a very important foundation for monetising any technological or therapeutic inventions," he said. "To say that this is the death of the biotech industry is a little precious when there are significant benefits to be gained from these techniques and therapies."

Professor Suthers said that even though Myriad had lost the patent to the BRCA genes, it still held a massive commercial advantage from the enormous database it had built up through the exclusive testing it had conducted for the last two decades.

This experience meant that it was far better equipped than its rivals to interpret the outcomes of BRCA tests.

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Push for nationwide child vaccination standards

Parents nationwide could face tough new vaccination requirements before they can enrol their children in school or childcare following a meeting of the country's health ministers.

But a meeting of Federal, State and Territory health ministers rejected calls for children not fully immunised to be banned from attending school.

Instead, the ministers discussed a range of proposals to boost child immunisation rates, including requiring parents to provide proof of their child's vaccination status before enrolling them in school.

Others measures discussed included informing parents of vaccination rates in their local area and possible pilot projects to refer children who are not fully immunised to GPs and other health services for catch-up vaccinations.

The push follows the introduction in New South Wales last month of significant new laws under which parents or guardians trying to enrol children in childcare will be required to provide evidence that their child has been fully vaccinated, is on a recognised vaccination catch-up schedule, or has a doctor-approved exemption on personal, philosophical, medical or religious grounds.

The move has come amid evidence that immunisation rates in pockets of the population have dropped well below 90 per cent, potentially allowing for the sustained outbreak of serious diseases such as measles.

Several states already have laws that require checks to be made of child immunisation status upon enrolment, but implementation has been patchy, and none require a schedule of catch-up inoculations.

AMA President Dr Steve Hambleton has backed measures to make it tougher for parents to enrol children who have not been fully immunised, but the Association has rejected hard line calls for children without up-to-date vaccinations to be banned from school.

Dr Hambleton said doctors supported an educative rather than punitive approach to lifting vaccination rates.

In NSW, where several pockets of low child vaccination rates have been identified, Health Minister Jillian Skinner affirmed that GPs have the legal right to refuse to sign forms for parents who conscientiously object to having their children immunised, potentially adding to difficulty parents face in enrolling unvaccinated children in child care centres in the nation's most populous state.

To obtain an exemption, parents will have to undergo counselling and make formal statements.

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Surgery 'most effective' in helping severely obese

Severely obese adults should be prescribed around five hours of moderate exercise a week and be considered for lap bands or other surgical weight loss techniques, the nation's top medical research organisation has advised.

Drawing on a worldwide review of the scientific literature, the National Health and Medical Research Council has drawn up guidelines for treating overweight and obesity in adults and children, including the recommendation that patients with a body mass index (BMI) greater than 40 kilograms per square metre should be considered for bariatric surgery.

But it is dismissive of so-called complementary weight loss therapies – such as acupressure, dietary supplements, homeopathy and hypnotherapy – because evidence of their effectiveness was "very limited".

Instead, doctors with seriously overweight and obese patients are advised to adopt a progressively more interventionist program.

While diet and lifestyle changes is the first approach doctors should take to treating overweight and obesity, the NHMRC said the use of "more intensive interventions" might be necessary, and should be considered when other approaches fail.

"Interventions are likely to be used sequentially — for example, starting with a very low-energy diet to achieve weight loss, then using medications to help counter the hormone changes and increased hunger that follow weight loss," the guidelines said. "Bariatric surgery is not generally an immediate consideration unless other interventions have not been successful or are contraindicated, or a patient's BMI is greater than 50 kilograms per square metre."

The Council said that although weight loss and management was primarily a patient's responsibility, doctors and other health care professionals had an important role to play in suggesting strategies and treatments, and providing monitoring and support.

"Early weight management gives children and adolescents the opportunity to learn positive lifestyle behaviours, and reduce their risk of obesity, diabetes and cardiovascular disease in adulthood"

"For many individuals, weight gain is hard to avoid and very difficult to reverse," it said. "People often have unrealistic expectations of how much weight loss is feasible, which can be reinforced by medial reports of weight loss 'success stories'."

The NHMRC found that, of all the approaches to treating obesity in adults, bariatric surgery was the most effective.

Research showed that it consistently achieved weight loss of greater than 10 per cent, sustained for more than five years.

By comparison, patients who improved their diet and increased exercise might initially lose up to 10 kilograms, but were likely to have returned to their starting weight within five years, and those who used medication to help complement diet and lifestyle changes met with mixed results.

Nonetheless, doctors treating overweight or obese patients should "strongly recommend" lifestyle changes, including diets that produce a daily energy deficit of 2500 kilojoules and exercise programs with around 300 minutes of moderate activity or 150 minutes of vigorous exertion.

To achieve sustained weight loss, doctors had to remain closely engaged with their patients, the NHMRC added.

It recommended that for the first three months of any weight loss program, doctors arrange fortnightly reviews with their patients, and plan for ongoing monitoring for the subsequent 12 months.

The Council was more reticent about recommending bariatric surgery for overweight or obese children or adolescents.

It said such techniques should only be undertaken by "a highly specialised surgical team within the framework of a multidisciplinary approach".

It warned that children with a waist-height ratio equal to, or greater than, 0.5 might need to be assessed for cardiovascular risk.

The NHMRC recommended that children aged between two and 18 years with a BMI above the 97th percentile on World Health Organisation growth charts be referred to a hospital or paediatrician, as should those younger than two years who are above the 97th percentile and are gaining weight rapidly.

It recommended that the goal for most overweight children was the maintenance of existing weight rather than weight loss, and that parents, carers and families be involved in devising and supporting lifestyle changes.

"Early weight management gives children and adolescents the opportunity to learn positive lifestyle behaviours, and reduce their risk of obesity, diabetes and cardiovascular disease in adulthood," the Council said.

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Doubts on how often vitamin D deficiency should be put to test

Medical experts have advised that vitamin D testing should only be conducted on patients showing symptoms of deficiency or considered to be at risk.

While acknowledging that vitamin D deficiency is associated with a range of serious conditions including rickets in children and osteoporosis in adults, the Royal College of Pathologists of Australia and NPS MedicineWise have both advised that routine testing is of little benefit in the general population.

The advice has come amid rapid growth in the conduct of vitamin D tests in the past decade, to the extent that they now account for around 10 per cent of Medicare spending on pathology services.

The surge in testing has accompanied increasing awareness of the seriousness of vitamin D deficiency, and indications that its prevalence is relatively widespread.

Research conducted by the Baker IDI Heart and Diabetes Institute estimated that 31 per cent of Australian adults had a vitamin D deficiency, which was assessed as severe in 4 per cent of cases, while a separate NSW-based study reported that up to 58 per cent of adults might have a deficiency of the vitamin.

The consequences of deficiency can be severe, according to a Department of Health and Ageing review of vitamin D testing protocols.

The Department said evidence showed that prolonged deficiency could case rickets in children, and osteoporosis and softening of the bones in adults, and be associated with chronic kidney disease, Crohn's disease and cystic fibrosis.

But while the consequences of vitamin D deficiency can be severe and estimates that the prevalence is relatively high, experts said there was little evidence to support the use of routine testing for the condition.

In an updated Position Statement issued last week, the College of Pathologists advised that "routine screening of healthy infants, children and adults for vitamin D deficiency is currently not recommended".

The College said testing should only be considered for adults and children showing symptoms of deficiency or who were at risk.

These included those with symptoms of osteoporosis, suffering chronic renal failure or conditions characterised by malabsorption, or children showing symptoms of rickets.

Risk factors include deep skin pigmentation, a severe lack of sun exposure, renal transplant recipients, patients on anticonvulsants and infants of mothers with established deficiency.

NPS MedicineWise clinical adviser Dr Andrew Boyden said that vitamin D testing was unlike routine screening for cancer, diabetes and heart problems, which had demonstrable health benefits.

"The consequences of routine testing in low-risk populations are unclear," Dr Boyden said. "There are limitations with vitamin D immunoassays, debate about optimal vitamin D levels and questions about the clinical significance of mild deficiency."

The College's Position Statement can be viewed at: http://www.rcpa.edu.au/static/file/Asset%20library/public%20documents/Policy%20Manual/Position%20Statements/Use%20and%20Interpretation%20of%20Vitamin%20D%20Testing.pdf

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Complacency could undermine cervical cancer success

Health Minister Tanya Plibersek has urged more women to have pap smears despite plunging rates of cervical cancer.

Ms Plibersek said that although "huge strides" had been made in preventing, screening for, diagnosing and treating cervical cancer, more women needed to have pap smears, particularly those aged between 20 and 69 years who were sexually active.

The Minister made her call as the Australian Institute of Health and Welfare released figures showing that the cervical cancer death rate among Australian women had halved since 1991, when the National Cervical Screening Program commenced.

According to the Institute, there were 631 new cases diagnosed in 2009, and 152 women died from cervical cancer in 2010. This was equivalent to nine new cases and two deaths per 100,000 women.

In all, 3.6 million women were screened under the program in 2010-11.

But the data point to a worrying decline in the proportion of women undertaking a pap smear, particularly those in the high risk group.

Pap smear testing rates among women aged between 20 and 69 years have been sliding for three consecutive years, down from 59 per cent in 2008-09 to 57 per cent in 2010-11, sparking concerns about complacency about the disease, which is the twelfth most common cancer affecting women.

"If you are a woman aged 18 to 69 [years], you cannot afford to be complacent," Ms Plibersek said. "If you haven't been screened in the last two years, make an appointment with your general practitioner or health centre now."

The Institute found that for every 1000 women screened, eight were found to have high grade cell abnormalities.

Mass immunisation of girls (and now boys) with the human papillomavirus vaccine is thought to have played an important role in brining the number of cervical cancer cases down.

But health experts have warned that it does not provide complete protection against all cancer-causing viruses, and women should continue to have regular pap smears.

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Rheumatoid arthritis not just a pain

People with rheumatoid arthritis not only are more likely to suffer severe pain, but also endure high levels of psychological distress and poor health compared with those without the condition, a report has found.

The study, issued by the Australian Institute of Health and Welfare, examined changes to rheumatoid arthritis management in Australia in the past decade.

Rheumatoid arthritis is an autoimmune disease where the body's immune system attacks its own tissues, and can cause painful swelling and stiffness of the joints.

The report found that the prevalence of rheumatoid arthritis has remained relatively unchanged in the 10 years, and affects around 2 per cent of the population.

The condition can develop at any age, but is more common in women, and in people aged 55 years and older.

People with rheumatoid arthritis were found to be almost three times more likely to report severe pain than those without the condition, as well as 1.7 times as likely to report high levels of psychological distress and 3.3 times more likely to suffer poor health.

The report found that although prevalence of the disease has remained constant over the past decade, the treatment and management of the disease has changed dramatically.

In 2003, a new class of medicine – biologic disease-modifying anti-rheumatic drugs – became available for the treatment of rheumatoid arthritis in Australia.

The number of times a year the drugs were administered during admitted hospital care more than doubled from 2608 to 6932 times between 2004-05 and 2010-11.

In 2008-9, the estimated health expenditure on rheumatoid arthritis was $318.7 million, with $273.6 million or 86 per cent spent on prescription medications.

AIHW spokeswoman Louise York said the indirect cost of managing rheumatoid arthritis was not known, but the effect of the disease on those with the condition was significant.

"Rheumatoid arthritis may lead to reduced workforce participation, increased costs of managing the condition, and an increased impact on carers," Ms York said.

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Health on the hill

Political news from the nation's capital

Mining giant promises to palm off states

Mining magnate Clive Palmer has pledged an $80 billion boost to health spending if his fledgling Palmer United Party wins the federal election.

And the billionaire has revived Kevin Rudd's proposal to bypass the states and provide Commonwealth health funding direct to public hospitals.

While there is little expectation that Mr Palmer's party will be a major presence in the next parliament, his candidature has thrown a wildcard into some electoral contests, including in the Queensland seat of Fairfax and the NSW bellwether seat, Eden-Monaro.

His high profile has fuelled speculation that he will be competitive in Fairfax, currently held by Liberal MP Alex Somlyay, but his party's is ranked an outside chance of winning even a single seat in the forthcoming election.

In a bold promise he is unlikely to have to deliver on, Mr Palmer said that, if PUP was installed in office at the 14 September poll, he would ensure an extra $80 billion was devoted to health care over three years, with much of the money going directly to hospitals rather than being disbursed by the states.

"Local community hospitals know what their needs are," Mr Palmer said in the *West Australian*. "Premiers like Campbell Newman only concentrate on money and how to divert these dollars to suit their own needs. We want to concentrate on people and how we help them."

The entrepreneur did not provide detailed costings for his health policy, but a Party spokesman said the funds would come from the existing Budget, suggesting a major reallocation of resources from other areas of spending.

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Cautious Dutton leaves hospitals off to-do list

Aspiring health minister Peter Dutton has hinted at plans to unwind federal involvement in state hospital systems and expand the role of private health funds while guaranteeing to protect frontline health services.

In a guarded interview in *The Australian Financial Review*, the Shadow Health Minister reiterated the Coalition's rhetoric to cut down on health bureaucracy and support frontline services.

"I can guarantee that we won't be proposing any cuts to frontline services," he said.

Mr Dutton has made no secret of the fact that the existence of several bodies set up by the Rudd and Gillard governments as part of reforms to federal-state health funding arrangements – including Medicare Locals, the Independent Hospital Pricing Authority and the National Health Performance Authority – are likely to be reviewed by an Abbott Government.

The Shadow Minister outlined a cautious approach to the health portfolio that stands in contrast to the ambitious program pursued by the Rudd Government.

He told the *AFR* he would return the health policy focus of the Commonwealth to primary care and away from what he saw as Labor's obsession with hospital funding.

"I think the responsibility of the Commonwealth predominantly is in the area of primary care, and that's the interface people see most," Mr Dutton told the *AFR*. "I think we should allow the states to run public hospitals."

He said the Federal Government should not take a completely hands-off approach, but neither does he want to emulate the level of involvement of the Gillard Government in hospital funding.

"I think we should demand more efficiency and better management, and health outcomes, as a result," Mr Dutton said. "But I don't think the Commonwealth should be obsessed about running public hospitals. Because if we are, our focus is drawn away from our core business, which is primary care and aged care."

"Our absolute desire is to get more money back to frontline services and away from well-intentioned bureaucrats who aren't involved in delivering services to patients."

The difficulty he is likely to confront in that, in order to ensure accountability and efficiency in the use of Commonwealth funds for public hospitals, Mr Dutton is likely to need the sort of information and supervision provided by the very institutions he wants to review if elected – raising doubts about how much money he will be able to free up in the existing health budget to fund his health policy priorities.

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Health on the hill

Political news from the nation's capital

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Govt plans pre-election Medicare ad blitz

The Federal Government plans to spend at least $6.5 million spruiking Medicare in a pre-election advertising blitz.

Department of Health and Ageing officials have revealed that $6.5 million is due to be spent on advertising before the end of this financial year, with up to a further $3.5 million allocated for 2013-14.

The officials, appearing before a Senate estimates hearing, said they were awaiting final approval for a national campaign.

According to the Budget papers, it would "inform Australians about the benefits of Medicare and health related services".

Health Minister Tanya Plibersek told Parliament the campaign would include "new elements of Medicare – the GP after-hours line, the personally controlled e-health record and Medicare Locals".

Liberal Senator Concetta Fierravanti-Wells was quoted in *The Australian Financial Review* accusing the Government of using the campaign to promote "signature" programs in the lead-up to the 14 September election.

"The Minister is using the cloak of Medicare to try and hide their political advertising in the lead-up to September," the Senator said.

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Super clinics on sick list

The Federal Government's much-vaunted GP Super Clinics program appears increasingly dead in the water, with evidence that just half of the 64 services promised are open for business.

Figures published by the *Daily Telegraph* show that of the 31 clinics announced in the 2007 election, six are yet to open, two have been scrapped and three need further funding.

In addition, just two of the 28 clinics promised in the 2010 poll have begun operations, while construction is yet to begin on 16 and contracts have not been signed for a further four.

The $650 million scheme has been heavily criticised by the AMA because in many places the clinics were not filling a gap in services but were in fact likely to operate in direct competition with existing practices.

The poor figures reflect concerns that in many instances the case for a government-funded clinic was not established and the scheme itself was poorly conceived.

AMA President Dr Steve Hambleton told the *Daily Telegraph* that whoever won the 14 September election should immediately halt any further spending on the program.

"The money should be reallocated to existing GP practices," Dr Hambleton said. "If four contracts are unsigned, they should be stopped instantly, and the money should be reallocated to existing practices.

But the Government is doggedly sticking with the program.

A spokesman for Health Minister Tanya Plibersek said 49 of the 64 clinics were either operating or "well underway".

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Mental health wins out over home care

The Federal Government has ramped up mental health care for current and former Defence personnel at the expense of services that help support war veterans and their widows living at home.

The Government has axed more than $25 million in funding provided to the states and territories under the National Partnership on Home and Community Care (HACC) – Services to Veterans program, with the money redirected to boost veteran access to mental health services.

The Commonwealth claims the reallocation of funding will have no effect on in-house care services for veterans because they already have full access to the HACC program "on the same basis as other members of the Australian community".

But the states have cried foul over the change, which strips them of Federal Government "facilitation payments" to support veteran access to HACC services. Victoria and Western Australia are particularly outraged because they received special HACC support supplements for veterans and war widows aged 65 years of age or older.

Victorian Health Minister David Davis has written to Veterans Affairs Minister Warren Snowdon urging him to reconsider the cut.

"This is a sad decision and it is the wrong decision," Mr Davis told the *Sunday Herald Sun*. "The purpose of this funding is to make sure we provide a high level of tailored support."

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Health on the hill

Political news from the nation's capital

...CONTINUED FROM PAGE 24

But the Government has so far rejected overtures to reverse the cut, which is being used to boost mental health services for current and former Australian Defence Force personnel and their families.

Under the changes, eligibility for counselling and treatment for "certain mental health conditions" will be expanded to include former members of the ADF and members of their immediate family.

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Pharmacists bumped off skilled migration list

Pharmacists have been removed from the list of professions eligible for permanent skilled migration.

As part of an annual review of the Skilled Occupations List, the Department of

Immigration and Citizenship has removed retail and hospital pharmacists and, reflecting the slowdown in the economy, has not added any new occupations, according to a report in *The Australian Financial Review*.

The change has been welcomed by The Pharmacy Guild, which has been pushing hard to have 'pharmacist' excised from the skilled occupation list.

According to the Guild, there is an oversupply of pharmacists in "most parts of Australia".

In recent years there has been an increase in the number of pharmacy schools, and a commensurate surge in the number of graduates – developments that had led to an increased burden for pharmacy owners, who are obliged to provide a year's internship for pharmacy graduates.

But the removal of pharmacists from the skilled migration list has concerned rural health groups who complain that there are not enough pharmacists serving rural communities.

Rural Health Alliance Executive Director Gordon Gregory told *The Australian Financial Review* that "there's a maldistribution, rather than undersupply, of pharmacists in rural areas".

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Push for nationwide child vaccination standards

...CONTINUED FROM PAGE 19

Childcare centres that fail to enforce the new standards face a $4000 fine.

Increasing the pressure on parents, the Commonwealth is moving to ensure those who object to vaccinating their children do not qualify for a childcare rebate.

The Department of Health and Ageing is changing the wording of exemption forms to replace the term 'conscientious objector' with 'vaccine refuser'.

AMA President Dr Steve Hambleton said the change in terminology was welcome.

"The reality is that there is no good medical reason to be a conscientious objector. 'Vaccine refuser' says it like it is. They should be named for what they do," Dr Hambleton said.

The so-called Australian Vaccination Network, which is vehemently anti-vaccination, is fighting a vigorous rearguard action against NSW Department of Fair Trading moves to force it to change its name.

NSW Opposition health spokesman Dr Andrew McDonald told the ABC the AVN's name was a serious problem.

"This is all about false advertising. The Australian Vaccination Network are doing whatever they can to keep their name near the top of a Google search," Dr McDonald said. "They're number two on a Google search if you use the words 'Australia' and 'vaccination', and that's why they want to preserve their name, to keep it there."

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Good things do come

BY **DR BRIAN MORTON**

"We are often confronted with decisions which seem bizarre at first glance, and which we must then carefully work through with Government to have them reversed"

Persistence pays for AMA. After many years seeking Medicare Benefit Schedule rebates for GP-referred MRIs, GPs should be able to refer child and adult patients for Medicare-eligible MRI scans from 1 November 2013, all things going to plan.

For a while it seemed that enhancing patient access to timely and affordable MRI scans was beyond our grasp.

It was tantalisingly close to being achieved in the lead up to the 2007 federal election, but with the change of government, the Department of Health and Ageing took the chance to render it dormant – a state in which it remained until some persistent AMA lobbying, with the support of the relevant Colleges, led the Government to announce funding for GP-referred MRI items in the 2011-12 Budget.

In what was no doubt a testing of the waters, GPs from 1 November 2012 were able to refer patients younger than 16 years of age for Medicare-eligible MRI scans for specific and clinically appropriate indications. This authority was then to have been expanded from 1 November 2013 to include patients older than 16 years, for a limited number of indications.

There has not been much noise following the implementation last year of the initial GP referred MRI items, which means that GPs have behaved completely responsibly with the new items.

We know that in all probability the introduction of the items has limited unnecessary tests, been beneficial for patients, and has saved dollars for the Government. That is why work towards expanding the items has been quietly progressing.

Having recently contributed to the development of the new items, I can say that it is very satisfying to see MBS items for GP referred MRI across the board becoming a reality.

For far too long patients needing an MRI had to be referred to a specialist to access a Medicare rebate for the scan, wasting time and expense in getting a diagnosis.

Cost control was the motivation behind such unnecessary and unwarranted restrictions.

As with most cost saving measures, they can be a bit short sighted, ultimately resulting in wastage and longer-term expenditure as a result of delayed diagnosis and treatment.

The descriptors still need to be finalised and formally approved, but it is expected the extension of the items will cover scans for a number of body areas for specific conditions, with effect from 1 November 2013.

This shows that if you can assemble the arguments and hold the line, persistence pays off.

It may be obvious to us what the Government should do, but we have to make it obvious to them.

The same applies in our dealings with Government across many areas.

We are often confronted with decisions which seem bizarre at first glance, and which we must then carefully work through with Government to have them reversed.

There were many decisions in the 2013-14 Budget that seem likely to add very substantially to patient out-of-pocket costs, which are already approaching the $5 billion mark.

Patient out-of-pocket costs is the fastest growing item of health expenditure.

In addition, the work-related self-education expenses cap will indirectly add to patient out-of-pockets and deter self-education and excellence. Either way the patient cops it.

This looks like another issue that will require the AMA's persistence to see common sense prevail.

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They're usually much slicker

BY **AMSA PRESIDENT BEN VENESS**

Police were on every corner, diverting foot traffic the long way 'round Capitol Hill. The President of the United States of America was inside.

Unlike in Canberra, politicians' offices in Washington DC are split between a large number of separate buildings. On this cold March morning in the US capital, long queues of coated and gloved citizens and lobbyists stretched out from building entrances.

Democratically, once through the metal detectors ("belts, off!"), you are free to knock on whatever door you please, no pass required. In Canberra, the equivalent level of access requires authorisation from two parliamentarians.

I found my own way to the correct room and waited outside. A few minutes later, 11 white-coated medical students from Tennessee click-clacked down the hall.

We were there to meet with two Congressional aides, in the hope of advancing the American Medical Student Association's advocacy agenda.

The meeting itself was rather odd. No official from the American Medical Student Association (AMSA) was present, so only the advisers and I thought it strange when the appointed spokesman started by announcing that AMSA had a lot of policies and that this group didn't agree with all of them.

Even among medical students, universal health care and gun control ("violence minimisation") are controversial in the land of the free and home of the brave.

Conversation meandered politely for 20 minutes or so. The young staffers looked at their watches and asked if there was anything else. The spokesman's final question was whether this had been typical of a lobbyist's meeting on the Hill.

"No," the male staffer chuckled in response. "They're usually much slicker."

The concept, however, had a lot of merit. Once home in Australia, I spoke about it with my team and we decided to adopt the idea for our own *National Leadership Development Seminar* in Canberra at the end of May, badging it "Meet your MP".

Each year, about 100 medical students from across Australia converge on Canberra to attend our highly popular three-day Seminar. The standard programme includes a number of presentations and workshops, a debate in Old Parliament House, a dinner, and attending Question Time.

This year a fantastic team of medical students organised the Seminar. Rahul Chatterjee, Matt Rubic, Emma Curé, Sara Ooi and Sian Myers put together an outstanding programme of guest speakers, including Dr Steve Hambleton and Associate Professor Brian Owler from the AMA.

Students raved about their personal favourites, including Muslim community leader Associate Professor Mohamad Abdalla and former Médecins Sans Frontières president Dr Nick Coatsworth.

For our new "Meet your MP" initiative, we wrote to delegates in advance and invited them to contact their Federal Member of Parliament to request a meeting at Parliament House.

Delegates were invited to select one or two of the Australian Medical Students' Association's policies that they were personally supportive of, and told that either myself or another member of the Executive would accompany them to the meeting.

We had quite a strong response from the students, and ended up with about 15 meetings over our three days in Canberra.

Delegates had been asked to research their MP's biography, first speech, recent media mentions, and views on the topic they planned to raise.

We held an hour-long briefing after dinner on the Sunday, and discussed strategy in advance of each meeting.

Overall, "Meet your MP" was a great success.

Some politicians engaged particularly well with the issues we raised; one called me yesterday to say he had followed up with Health Minister Tanya Plibersek while together in the chamber, and relayed their conversation about internship prioritisation lists.

We now have another advocate on this issue, and some more letters to write.

Perhaps the best testament for the initiative is this, from Western Australian student, Matthew Palladino's Facebook page: "Just had a chat with the local MP at Parliament House. Turns out they're actually really friendly, easy to meet and interested in what you have to say. Completely overturned my mental image of a politician!"

I can imagine the cynics' replies, but am nonetheless thrilled to have incorporated such a tangible exercise in direct political advocacy into our Seminar's agenda.

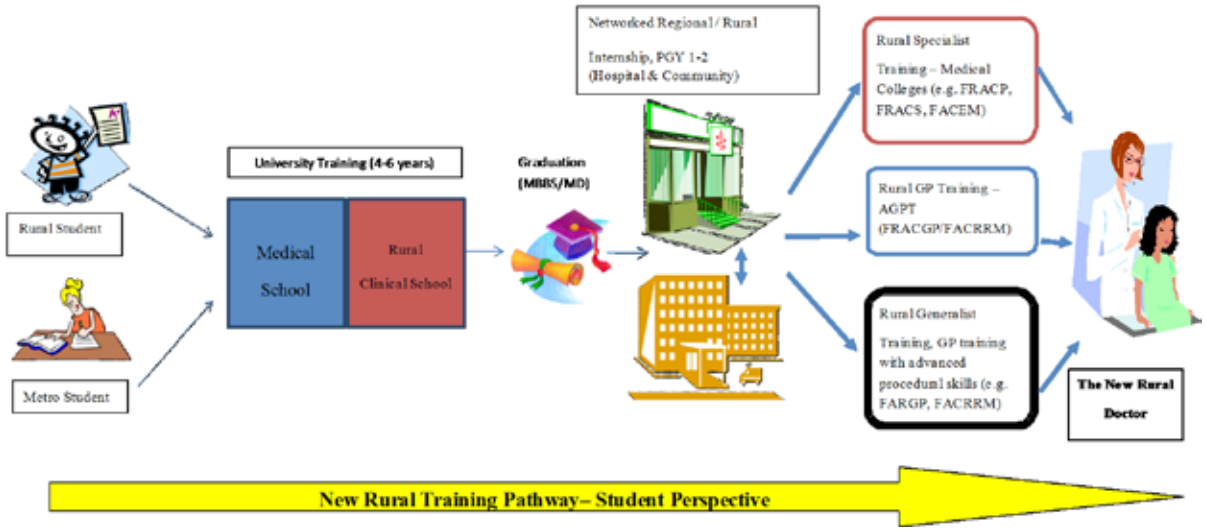
Matthew and the other students were outstanding, and gave me yet more faith in the future of our profession. Will the AMA continue to engage them as strongly?

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

TO COMMENT CLICK HERE

The Mason Report – the good, the bad, and the bureaucratic

BY **DR DAVID RIVETT**



The Government recently released the findings of its Review of Australian Government Health Workforce Programs, chaired by Jennifer Mason. At 451 pages, this is not a report for the faint-hearted.

It is a detailed, scholarly - almost encyclopaedic - update on the national health workforce and the Federal Department of Health's workforce programs.

Truly a great reference source with much up to date data, it is a must read for all serious medico-political aspirants in the AMA. The AMA Council of Doctors In Training representatives, in particular, must have a long and detailed look at these recommendations.

It has some 87 recommendations, too many to comment on in 400 words. Some are a positive way forward; some are driven by a bureaucratic desire to ease the administrative workload or buttress the role of new you-beaut-but-failing government creations; some are dangerously misguided. But some are plain commonsense and will, I am sure, garner AMA support.

The basic assertion that we need better data collection, monitoring and evaluation of the effectiveness all workforce programs deserves our support, as does the underlying principle that better distribution of new graduates needs to be the priority, rather than just increasing their numbers.

The recommendation to replace ASGC-RA with a revised geographical classification system is welcome, but it will not happen quickly if another expert committee is set up to implement it and at least 12 months is allowed to introduce it.

The recommended rural training pathway revamp (as set out in the accompanying diagram) looks great, encompassing not just GPs but generalist and other specialty training.

The recommendations to improve support for Overseas Trained Doctors, to better inform them, and to consider allowing them and their families access to Medicare are excellent.

The proposed changes to District of Workforce Classification look good to me. As do the proposed changes to the Bonded Medical Places scheme.

However, suggesting that bonded medicos can meet their return of service obligations by working in GP Super Clinics (the Government announced around 60 GP Super Clinics in 2007, and 36 were promised to be fully operational by 30 June this year, but only 24 are now open) is a desperate suggestion to save face for the current Government. As is the proposal that military service be an option for bonded scholars.

Placing GPRIP (General Practice Rural Incentive Program) funds, (that is, retention and relocation funds), in the hands of Medicare Locals is recommended. However, this is merely a thoughtful bureaucrat trying to find a use for Medicare Locals to appease the politicians of the day.

Given what Medicare Locals have recently done to both pocket and diminish after hours payments to GPs, it is a recipe for revolution from rural GPs. No mention is made of the fact that these payments have never been indexed, nor that they are all taxable, which greatly diminishes their impact.

In fact, no mention of increased funding is made anywhere in the Review which, overall, has the feel a report constructed within strict guidelines to appease government and bureaucracy. Nevertheless, it is a worthwhile read and a very thought-provoking document.

TO COMMENT CLICK HERE

AMA ensures doctors are heard on medicine regulation

BY **PROFESSOR GEOFFREY DOBB**

"TGA is steadily working its way through the commitments it has made in this Blueprint, and seeking comment on how reforms should be implemented"

The Therapeutic Goods Administration (TGA) has lifted its game in the way it communicates and engages with stakeholders such as the AMA.

In the last 18 months it has run a series of public consultations on a range of policy and regulatory issues.

It is important for the AMA to be highly engaged in TGA policy and regulatory development activities because of the significant impact these can have on medical practitioners.

Providing advice on how the AMA should respond to these consultations has made up a significant proportion of the Therapeutic Committee's work.

Some of the TGA's consultations are a direct result of the review conducted in 2011 on the way the TGA interacts with stakeholders and the general public.

In early 2012, the TGA announced its 'Blueprint for Reform', a culmination of the review findings and recommendations.

TGA is steadily working its way through the commitments it has made in this Blueprint, and seeking comment on how reforms should be implemented.

The TGA is also consulting regarding a number of regulatory decisions that will have to be made in advance of the July 2016 deadline for establishing the new joint Australian and New Zealand Therapeutic Products Regulatory Scheme.

Here are some examples of the consultations the AMA has responded to recently, informed by advice from the Therapeutics Committee:

- the development of a consistent trans-Tasman early warning system for safety concerns with medicines and medical devices, that would alert health professionals and consumers to all serious safety signals once they are detected;
- the development of a combined Australian and New Zealand publicly accessible database of adverse event notifications relating to medicines and devices;
- a review of regulations relating to the labeling and packaging of medicines, focusing on consumer safety issues and the visual aspects of information presented;
- proposed amendments to pre-market assessment requirements for medical devices that attempt to increase scrutiny of higher risk devices while reducing the regulatory burden on lower risk devices;
- proposed improvements to product and consumer medicine information documents, such as changing the order of information so that clinically relevant information is moved to the front; and
- proposed changes to TGA legislation to more effectively prevent products from being registered using the TGA's electronic listing facility where there is insufficient evidence to support therapeutic claims.

If you have particular views on these issues, the Therapeutics Committee would like to hear from you.

You can find more information about TGA consultations, including the AMA's submissions, on the TGA's website at: http://www.tga.gov.au/newsroom/consult.htm

TO COMMENT CLICK HERE

Members' Forum

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

AMA President Dr Steve Hambleton used his Presidential Statement at National Conference to set the tone for how the AMA will perform during the 'real' Federal Election campaign, which is due to kick off in early August ahead of polling day on 14 September.AMA Members expressed some of their frustrations leading up to the election.

Tax treatment of self-education expenses

We're reading this one wrong. In view of the fact that our ability to earn our income is related to continuing medical education by Government diktat, it is a necessary cost of doing business like rent and staff wages.

Whether we choose to do so five star or by the internet is irrelevant to the deduction, in the same way as whether you pay rent in Macquarie Street or a shed in Burke - the whole rent remains a deduction.

This Government decree is a sham without a major change to the Taxation Act for business!

Submitted by Dr Pat Gibney (not verified)

Revalidation: do doctors need it?

The Medical Board has proposed that doctors in future undertake regular evaluations of their competence and fitness to practice that go beyond current accreditation, registration and continuing professional development (CPD) standards. Many AMA members were concerned about the possible introduction of revalidation.

It is just too hard for a semi-retired doctor to do. Although I have been working some sessions per month - by request of the employer - it is both difficult and expensive to maintain even the present CPD. I have no choice but to retire completely.

Submitted by Edward Brentnall (not verified)

It is getting way too much. I face CPD assessment from my college, revalidation for my colonoscopy every three years, annual ISO certification of my practise, and now the prospect of annual APHRA revalidation. All for no proven benefit, but merely to produce an inner feeling of dogoodedness from those who no longer practise clinical medicine. If our representative colleges and associations can no longer effectively stem this tsunami of pointless red tape, we will have to seek other means of protest.

Submitted by John Lancaster (not verified)

I am amongst the rural GPs still performing anaesthetics, obstetrics (including caesarean sections) and some surgery. There are now available wonderful educational opportunities - I could spend all my time being educated, but not see any patients. How will revalidation affect us? Finish us off?

Submitted by John Rosser Davies (not verified)

Surely we'll all have to substantially increase our fees to cover the time spent jumping through government hoops.

Submitted by Dr Char Gemore (not verified)

I see no persuasive factual argument for this. If there could be problems then why not improve continuing medical education, rather than start yet another system.

Australians generally are facing increasing regulation in many areas for little tangible benefit, and the red tape is starting to strangle the country with increased costs.

The views of working, coalface doctors need to be involved in any changes. The case still hasn't been made in my view.

Submitted by B (not verified)

Coal seam gas fears

Coal seam gas developments should be blocked where there is any doubt about their potential to cause serious and irreversible harm to health, according to the AMA. Coal seam gas seemed to worry many AMA doctors....

My niece and her husband are medical doctors travelling the world, mainly in undeveloped countries, setting up hospital emergency centres, midwifery clinics and more. These are things Australians take for granted, like our unspoiled open spaces, fresh water and first class food bowls. Coal seam gas is very close to changing all that in the next 10 to 20 years. The respect the AMA holds in the Australian community is your ticket to getting your message out there to the community, letting them know of the risks with this industry. "Press on, persistence is omnipotent ..."

Submitted by Bruce Derkenne (not verified)

TO COMMENT CLICK HERE

What do you mean, dead?

Nightmarish scenarios in which patients pronounced dead spontaneously recover have gripped public attention to an extent that outstrips the frequency with which they have occurred.

But they can loom large in the minds of family confronted with the decision of whether or not life support machinery should be turned off – particularly when the option of organ donation is raised.

Gone are the days when it was simply a matter of determining if someone had stopped breathing and the heart had ceased to beat.

The advent of brain scanners, heart and lung respirators and other technologies has complicated the equation, and standards about what exactly indicates death vary widely around the world.

In some countries, a circulatory system that is inert for more than two minutes is considered sufficient time to diagnose that a person has died, while in other places inactivity has to be observed for no less than five minutes, and by at least three doctors.

In Australia, the standard diagnosis of circulatory death involves two senior doctors independently observing and clarifying permanent circulatory arrest lasting at least five minutes.

As one physician who attended a meeting of European anaesthetists earlier this month dryly observed, they can't all be right.

That is why two senior anaesthetists have called for a global consensus on what is required to diagnose death.

Speaking at the European Society of Anaesthesiology's annual congress on 3 June, Associate Professor Ricard Valero Castell of the University of Barcelona and Bristol-based consultant anaesthetists and intensive care specialist Dr Alex Manara urged practitioners worldwide to participate in work being undertaken by the World Health Organisation to establish a common definition of what constitutes the end of life.

Associate Professor Valero told the conference that until the twentieth century, determining that a patient was in a coma, suffered apnoea and lacked a pulse was sufficient to diagnose death.

He said the advent last century of more sophisticated technologies that monitor brain activity brought with them significant change in how death was defined, as well as significant ethical and scientific challenges that are yet to be resolved.

"For this diagnosis [of brain death], it is essential to demonstrate irreversible coma, absence of response to stimuli and absence of brainstem reflexes," Associate Professor Valero said. "However, there is no global consensus on what are the detailed diagnostic criteria for this determination in clinical practice, such as the number of physicians needed to agree on the diagnosis, how many and which reflexes need to be examined, length of observation periods, and use of additional tests to confirm death.

For example, in Spain three doctors are required to observe a patient for no less than five minutes and concur in order for death to be diagnosed. But in the UK it is recommended that two doctors attend, and in Canada one. Furthermore, in many institutions in the US, patient observation for two minutes is deemed sufficient to establish that death has occurred.

Dr Manara bemoaned that there has been even less work done on what constitutes a standard diagnosis of death involving circulatory and respiratory criteria.

He argued that, with 56 million deaths worldwide each year, "we know all there is to know about death", but this was not the case.

Dr Manara said there remained serious and substantial gaps in knowledge, and a lack of agreement on what constituted the diagnosis of death.

"There needs to be consensus around a practical and concrete definition of death that describes the state of human death based on measurable and observable biomedical standards," he said.

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What do you mean, dead?

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"Westmead Hospital intensive care specialist Dr Martin Cullen agreed it was "a bit strange" that there was not yet international agreement on how to determine when someone had died"

An expert forum organised by the Canadian Blood Services in collaboration with the World Health Organisation developed an operational definition of death, which determined that it occurred where there was a permanent loss of capacity for consciousness and all brain stem functions, meaning a loss that cannot resume spontaneously or be restored through intervention.

But Dr Manara said this definition left important issues unresolved.

He said the point at which a loss of circulation was irreversible remained vague, vared by patient and depended on the equipment, facilities and expertise available.

Dr Manara suggested protocols that required physicians to continually observe an apparently deceased patient for at least five minutes following presumed death should eliminate the possibility that a spontaneous recovery would occur after death had been pronounced.

This should become the minimum standard for declaration of death by circulatory criteria, Dr Manara told the conference, and would help to maintain professional and public confidence in the diagnosis of death, "both after terminating CPR, and in the context of organ donation after the circulatory determination of death".

Westmead Hospital intensive care specialist Dr Martin Cullen agreed it was "a bit strange" that there was not yet international agreement on how to determine when someone had died.

He said diagnosing circulatory death was relatively straightforward by comparison with establishing that brain death had occurred.

Dr Cullen said that to diagnose brain death, a patient's condition first had to be normalised, and factors that might confound the picture – such as the presence of sedatives or paralytic agents, or electrolyte of blood sugar imbalances - had to be discounted.

If the patient was normalised but still remained unconscious, was not making any breathing effort, and there was no sign of any brain stem reflex, that would usually be sufficient for two senior doctors to independently verify that brain death had occurred.

Dr Cullen said establishing a uniform international standard for the diagnosis of death would be "nice" rather than vital, adding that cultural differences – particularly when it came to understanding and accepting the concept of brain death – were likely to be a significant barrier to be overcome.

He said his personal experience was that many people of Middle Eastern background, in particular, found it difficult to accept the concept of brain death.

The importance of well-established criteria for diagnosing death has been underlined by changes underway in China regarding the harvesting of donor organs, particularly from condemned prisoners.

Director of the China Organ Transplant Response System Research Center at the Ministry of Health Haibo Wang told the WHO late last year that the country was gradually moving away from a transplant system reliant on the donation of organs from condemned prisoners, and public confidence in the ability of physicians to diagnose death was instrumental in building up donation rates among the broader population.

Mr Haibo said reliance on organs donated by condemned inmates was neither ethical nor sustainable, and this had been recognised by those involved in the organ donation system.

But he said the transition to reliance on a broader donor population had been complicated by the lack of a legal definition for brain death in the country.

Mr Haibo said a pilot project had found that just 9 per cent of organ donations were made on following declared brain death, underlining the urgent need to amend the law.

"Lack of legislation can put the medical professionals engaged in organ transplantation at legal risk, that's one reason why we are extremely careful in designing the national protocol when it comes to organ procurement from patients pronounced dead based on neurological criteria [brain death]," he said. "However, transplant professionals should not be the sole and main drivers of death determination criteria and legal requirements, as this would present a conflict of interest and raise public concern."

He admitted that, even with brain death legislation, "there is no guarantee of the success of donation in terms of public willingness to donate".

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Research

Scotland takes high road in making human blood

Scottish researchers have been given licence to use stem cells to manufacture blood that could be eventually tested on people.

The licence allows the researchers to establish a manufacturing facility used to develop human cell therapy products.

The researchers aim to produce blood that would be fit for clinical trials.

Researchers will use stem cells from adult donors – induced pluripotent stem cells – for the research, instead of embryonic cells.

Lead researcher Professor Marc Turner from the Scottish National Blood Transfusion Service said initially researchers had had to use human embryonic stem cell lines, and one of the problems with this was that there was no ability to choose the blood group.

"Over the last few years, there has been a lot of work on induced pluripotent stem cells and with those, an adult can donate a small piece of skin or blood sample and the technology allows for stem-cell lines to be derived from that sample," Professor Turner said.

"This makes our life a lot easier, because that means we can identify a person with specific blood type we want and get them to donate a sample, from which we could manufacture the cell lines."

Scottish Health Secretary Alex Neil said that Scotland has a world-class reputation in regenerative medicine and stem cell research.

"The completion of this state of the art facility will further advance our understanding of the debilitating diseases this field seeks to address and their personal therapies," Mr Neil said.

"This will allow for both the health and wealth benefits to be realised in Scotland, supporting the life science sector in its growth aspirations."

If successful, any future human trials would be the first stage in establishing larger-scale clinical trials, which could lead to the regular use of synthetic blood.

The Scottish National Blood Transfusion Service, Edinburgh University and Roslin Cells are conducting the work with the manufacturing facility based at the Scottish Centre for Regenerative Medicine.

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Researchers uncover secrets of immune development

The ability to take action to prevent the development of serious diseases such as diabetes and asthma even before a baby is born is a step closer following a breakthrough by University of Sydney researchers

A four-year study lead by Professor Ralph Nanan found that mothers appear to program their baby's immune system during gestation.

According to Professor Nanan and his fellow researchers, the immune systems of both the mother and her developing baby are highly synchronised, likely through pregnancy-related hormones.

Professor Nanan said environmental and genetic factors program the development of disease, and the first environment we are exposed to as humans is our mother's womb. He said common conditions like diabetes and allergies are associated with inflammation that is not well controlled by the immune system.

"The capacity to control inflammation is likely to be predetermined in utero. This suggests foetal immune programming is a central mechanism in the developmental origin of disease," Professor Nanan said.

"For example, if the mother's nutritional status is low, the baby will have an increased risk of developing diabetes and cardiovascular disease later in life.

"This process has been poorly understood until now. But our study has discovered the first evidence of a link between the immune systems of mother and baby.

"We might be able to prevent some conditions at a very early state. That's the novelty of this project."

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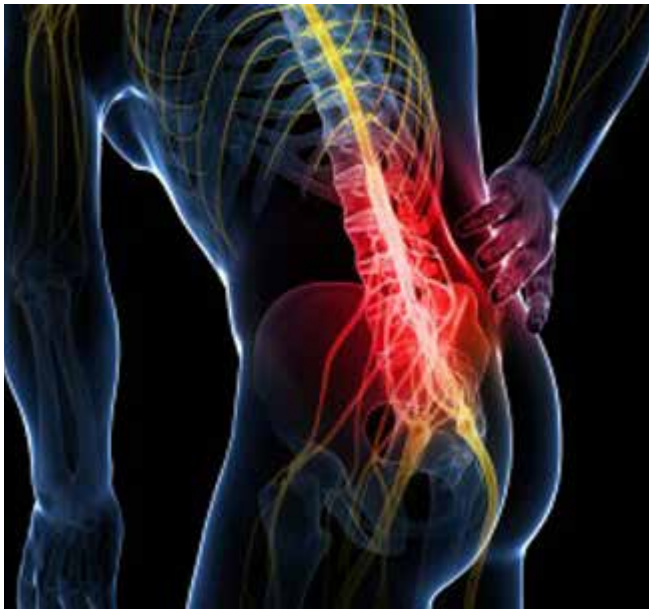
Research

Back pain breakthrough crippled by doubt



Claims that much chronic lower back pain was caused by a common bacterial infection and could be relieved with the use of antibiotics have become mired in controversy amid allegations of potential conflicts of interest.

As reported in *Australian Medicine* on May 20, the peer reviewed European Spine Journal earlier this year published a study claiming to show that up to 40 per cent of lower back pain was caused by a common bacterial infection that could be cured with antibiotics.

Based on a randomised double blind trial, the study concluded that treating patients with chronic lower back pain associated with vertebral bone edema for 100 days with a combination of amoxicillin with clavulanic acid reduced disability and pain, compared with 162 patients given a placebo.

But, since its release, the study has been surrounded by controversy.

Several researchers have questioned the methodology used in the study, and it has also been dogged by concerns about the failure of three authors to disclose the fact that they served on the board of a UK company that receives money to certify doctors in antibiotic therapy.

The publicly listed Modic Antibiotic Spine Therapy (MAST) Academy operates to educate the public and medical professionals on medic – bone edema (swelling) in the vertebrae that can only be detected by an MRI - back pain, and to certify clinicians in how to identify and treat the condition for a €200 ($314) fee.

Deakin University pain specialist Dr Michael Vagg told the *Sydney Morning Herald* that, while a link between bacterial infections and some back pain was plausible, the researchers had not demonstrated this type [microbe Propionibacterium acnes] of infection was the cause of pain.

"The paper only described a reduction in pain, so the idea that antibiotics could cure 40 per cent of back pain was misleading and overblown," Dr Vagg said. "They don't have the science to entitle them to make the sort of claims they are making."

Dr Charles Douglas, a medical ethics academic at the University of Newcastle, said that if the authors had one eye on the financial potential when they submitted their paper, they had a conflict of interest that they should have declared.

One of the authors, MAST Academy Board member Professor Claus Manniche, said the company was established in 2010, but remained dormant and without a bank account until after the manuscripts were accepted for the publication.

Professor Manniche said the *Journal* had been told of their involvement with MAST Academy, but did not clarify whether this occurred before or after publication.

Another author, Dr Joan Solgaard, said she had never heard of the MAST Academy until a month ago, when she was asked to be a Board member. She said she held no ownership stake in the company.

British spine surgeon Professor Peter Hamlyn, who was quick to hail the study's findings as "the stuff of Nobel prizes", stood by his comments despite the controversy.

"We are not talking about some rare condition; we are talking about low back pain," Professor Hamlyn said. "Eight per cent of the planet gets severe, persistent lower back pain and [these] discoveries may help 20 to 40 per cent of them. I do not have to be paid to say [the lead author] needs a Nobel Prize".

KW

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Tobacco companies running out of luck as Irish join plain packaging fray

The Australian Government could have the backing of the Irish Government and, possibly, the European Union in its fight to uphold tobacco plain packaging laws.

Irish Health Minister Dr James Reilly has announced plans for plain packaging laws to be enacted in Ireland early next year, which would make Ireland the second country in the world after Australia to have introduced such legislation.

Announcing the move, Dr Reilly told ABC radio it had the potential to save hundreds of thousands of lives each year if it was adopted across the European Union.

While the prospect of that still appears a long way off, Dr Reilly said he was confident the new laws would be passed in Ireland with the support of the Irish Taoiseach [Prime Minister] Enda Kenny.

"I've written a letter to my Taoiseach, I have spoken to him on the phone," Dr Reilly told the ABC. "I want Ireland, and I want him to use his support as well in Europe to back Australia at the World Trade Organisation."

The Australian plain packaging laws came into effect late last year after a High Court challenge mounted by the major tobacco companies was dismissed.

But four tobacco exporting countries – Ukraine, Honduras, Cuba and the Dominican Republic – have complained to the WTO that the laws breach trade rules protecting intellectual property rights, and a determination on the action is yet to be made.

Dr Reilly said he was "pretty certain" the Irish Government would support Australia in defending its right to enact the plain packaging laws.

"I really, genuinely want to commend the Australian Government for showing the leadership that they've shown, and we intend to carry on, on this side of the world, that same battle, because too many lives have been lost," he said.

New Zealand and Scotland have also flagged their intention to phase out branding on cigarette packets, though neither government has yet set a timeline for the introduction of such legislation.

And the United Kingdom Prime Minister David Cameron earlier this year dumped plans to include plain packaging laws in an outline of his Government's legislative agenda, prompting questions about the influence of key adviser Lynton Crosby (a key figure in the Australian Liberal Party during the Howard Government), whose consultancy has advised the tobacco industry in Australia.

The political influence of Big Tobacco has also sparked controversy in Ireland, where it was revealed that Mr Kenny and two senior Government Ministers met privately with tobacco company executives who were keen to head off any Irish interest in plain packaging laws.

Tobacco companies claim such laws will do nothing to discourage new or existing smokers, and will instead fuel the black market trade in cigarettes and other tobacco products.

But Dr Reilly and Australian Health Minister Tanya Plibersek said there was no substance to the argument, and the fact that big tobacco companies were prepared to fight so hard against these laws showed that they were effective.

"This is classic tobacco industry," Dr Reilly said on ABC radio. "Let's not talk about the evidence that this kills people. Let's talk about smuggling instead, and try and keep the argument over there."

Ms Plibersek said that although the plain packaging laws were unlikely to immediately reduce smoking, they were undoubtedly effective.

"The fact that Big Tobacco's throwing so much money at trying to overturn Australia's plain packaging legislation shows that it will work; it shows that they know it will work," the Minister told *The Australian*.

AR

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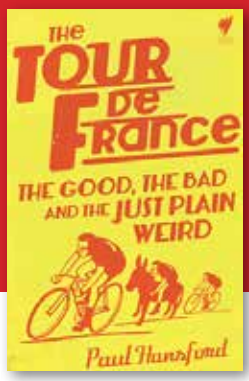
BOOK REVIEW



The Tour de France: The good, the bad and the just plain weird

By Paul Hansford

Hardie Grant Books, RRP $24.95, pp183, ISBN 978-1-7427-0637-5
Reviewed by Adrian Rollins*

Long before Lance Armstrong appeared on the Oprah Winfrey show to give a sanitised confession to systematic doping through seven Tour de France victories, another multiple Tour winner was asked on television whether or not he took performance enhancing drugs.

Italian Fausto Coppi, who won the race in 1949 and 1952, was questioned after he had retired whether he ever took drugs.

His frank reply was: "Only when necessary."

To the follow-up question, 'How often was necessary?', the blunt response was: "Practically all the time".

When 179 cyclists line up at the Tour de France start line in Corsica on 29 June, it will be a moment inevitably tainted by the drug-taking scandal that saw Armstrong stripped of the seven titles he won between 1999 and 2005, and many other riders of his era scrubbed from the record books.

It may be too much to hope that the historic 2013 edition – being held 100 years after the first race – will not be marred by any positive dope tests.

But recent victories by Cadel Evans and Bradley Wiggins have helped rebuild some faith that (as far as we know) athletes do not have to take drugs to win what is one of the toughest sporting challenges on the planet.

However, as Paul Hansford's entertaining and easy-to-read history of the Tour, *The Tour de France: The good, the bad and the just plain weird*, makes clear, it certainly does help.

Virtually from the time of the first pedal stroke in 1903, riders have turned to everything from champagne and amphetamines to blood transfusions and erythropoietin (EPO) to boost their performance and get an advantage over their rivals.

In some ways, it is not hard to see why.

As Hansford recounts, in its early years the Tour was more of a sadistic lab experiment than a sporting contest.

Its architect, Henri Desgrange, described his ideal Tour as one in which "only one rider survived the ordeal", and he set courses that went a long way to achieving this goal.

In the first three decades of the Tour, stages longer that 300 kilometres were the norm.

In 1919, the longest-ever Tour stage covered 482 kilometres, and in 1924 almost all the stages were more than 300 kilometres long – including five extending more than 400 kilometres.

Considering the basic standard of the roads and equipment of day – tarmac was almost non-existent outside the major towns, bikes had just two gears and weighed close to 20 kilograms, and clothes were made of wool – these were brutal challenges.

One stage in the 1924 Tour has gone down in history as 'The Circle of Death', and involved sending cyclists over the Pyrenees through atrocious weather. The winner spent 17 hours in the saddle and more than 20 competitors were still unaccounted for at midnight.

To top it all, Desgrange insisted that racers had to complete every stage with no outside assistance – leading to the legendary story from the 1913 Tour, in which race favourite Eugene Christophe had to repair a broken front fork himself at a blacksmith on the lower slopes of the Col du Tourmalet.

As Hansford promises in his Introduction, the book provides a handy overview of the Tour, particularly for those relatively new to the sport, including a guide to the arcane language, traditions and race tactics of one of the world's foremost sporting events.

But its real strength lies in bringing the Tour's rich history to life. It is crowded with anecdotes and character sketches from the many strange people and incidents that have marked its course in the past 100 years.

For cycling fans, this Tour promises to be one of the most open for years, not least because of the withdrawal of last year's winner, Bradley Wiggins.

Cadel Evans showed in the Giro d'Italia that he has the form to be at the front of a Grand Tour, as has Movistar's Alejandro Valverde.

Wiggins' Team Sky teammate Christopher Froome is also seen as a strong contender, though the front-runner will be two-time winner Alberto Contador.

If he wins, it will be a significant achievement - just try to forget that he was stripped of his 2010 title because of a positive drug test…

** Adrian Rollins is Australian Medicine editor*

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