AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

United front to Scrap the Cap

Professions join AMA in campaign against $2000 expenses cap, p6

Inside

See you in court: eye doctors take on regulators, p8
AMA heads off benzodiazapine rule change, p10
PCEHR falls short of start-up target, p16
Child vaccination rates 'alarmingly low', p17x
Practices stung by scammers, p18
Australia's Le Tour de High Country, p35

AMA
ISSUE 25.14 - JULY 15 2013

CPD TRACKER

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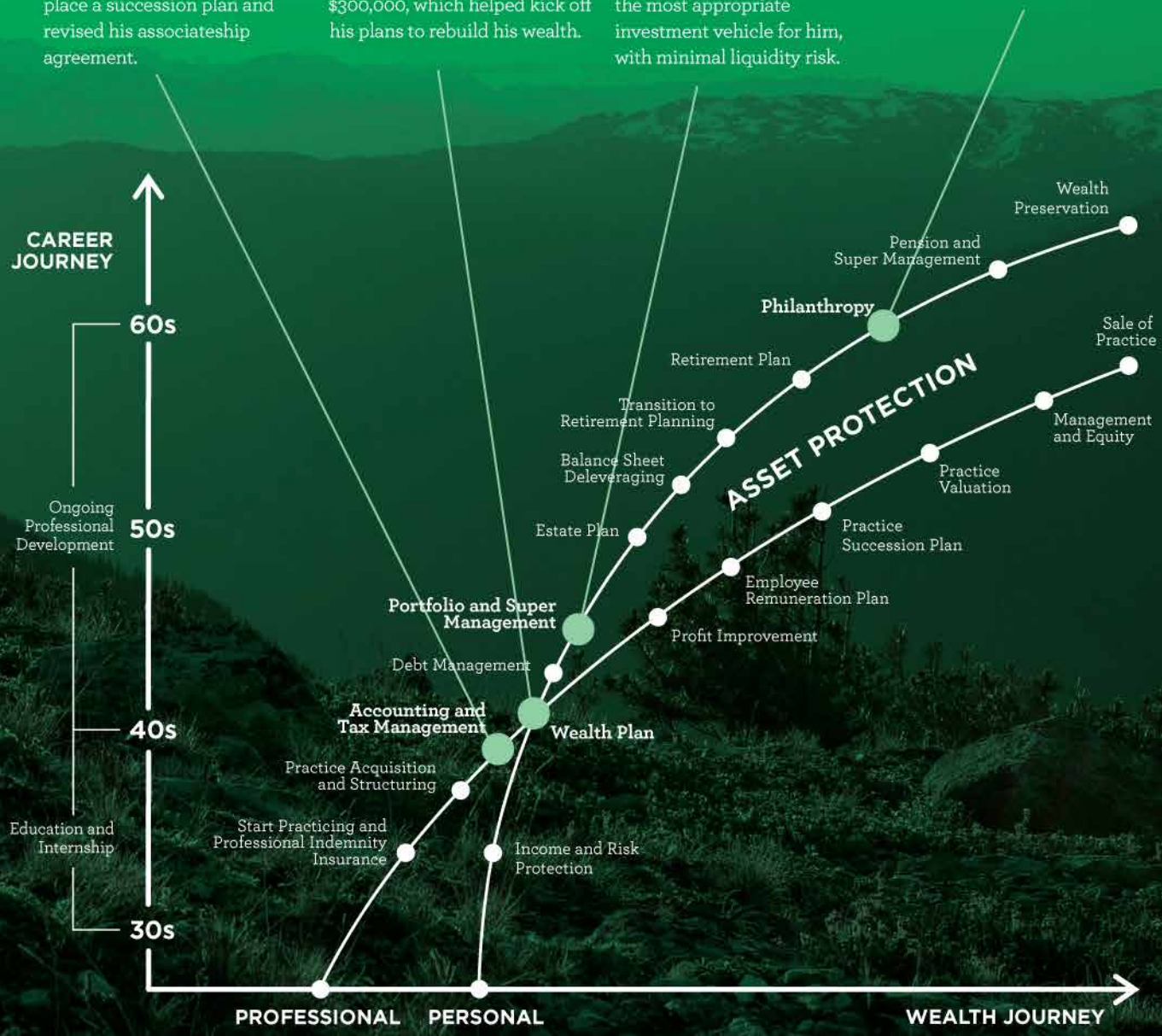

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IN THIS ISSUE

NEWS

6-21, 32-34

REGULAR FEATURES

5 VICE PRESIDENT'S MESSAGE
22 OPINION
23 GENERAL PRACTICE
24 AMSA
25 RURAL HEALTH
26 ETHICS AND MEDICO-LEGAL
27 HEALTHY AGEING
28 HEALTH ON THE HILL
30 MEMBERS' FORUM
31 RESEARCH
35 TRAVEL
37 WINE
38 MEMBER SERVICES

A Big Bad Tax on Learning

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Few recent issues have united the profession as much as the proposed $2000 cap on tax deductions for ongoing professional education expenses.

The Treasury has released a discussion paper on the change, which inspires no confidence that it has any insight into the consequences that a $2000 cap would have.

The discussion paper's title, Reform to deductions for education expenses, illustrates just how devalued the word 'reform' has become.

While often thought of as meaning a change for the better, it must now be added to the lexicon of weasel words, because the changes outlined are clearly a change for the worse.

The discussion paper acknowledges that, "Many professionals and employees are required to undertake further training to ensure their knowledge remains up to date."

For doctors, this is an essential requirement of continuing registration as a medical practitioner.

The first four pages of the discussion paper are devoted to the current tax treatment of education expenses - these will be well known to your accountant. The principles of apportionment that should prevent rorting are clear.

The tax deductibility of education expenses has also been tested in the courts.

The discussion paper implies that a reason for the $2000 cap is to override these precedents.

However, parts of the discussion document are unclear.

For example, it says that expenses for travel from home to a place of education and back will count towards the $2000 cap. But, in section 51, it suggests travel expenses will be among a range of deductions that will not be affected by the tax change, "provided they meet the necessary tests".

It is hard to think of a rationale for other essential work-related travel expenses being tax deductable while those related to essential continuing education are not.

The fringe benefits implications are also unclear.

In section 62 the paper states, "The government will ensure FBT will not apply to training or reimbursement by an employer, except where part of a salary packaging arrangement." Yet in section 68 it suggests that the, "otherwise deductable rule may no longer apply to education expenses in excess of the $2000 cap." What does the 'may' mean in this context - does it apply or not?

The discussion paper tries to justify the cap on equity grounds.

Yet it appears employers will be able to claim a deduction for expenses incurred in educating employees while self-employed medical practitioners will not.

For health, the policy settings seem all wrong. The implication is that we should simply do the minimum required to satisfy CPD requirements.

It is a policy aimed at mediocrity rather than excellence and innovation.

It is a policy that fails to recognise the diversity of need for continuing education.

Medical practitioners working in rural Australia necessarily incur greater expenses in maintaining their CPD because of greater travel expenses.

Doctors working in highly specialised areas are unlikely to find the exposure to new developments and techniques in Australia and must necessarily travel for this, often to Europe or the USA.

They incur a loss of income while away, so these visits are generally as short as possible. A five-day return trip to Europe in a cold, wet March to attend a conference or seminar for 12-hour days may be someone's idea of fun, but it's certainly no holiday.

I work in intensive care. Some of the innovations I have brought back to my work place after educational events overseas include the use of continuous positive airway pressure for adults and arteriovenous haemofiltration for acute renal failure.

I was happy to share these innovations with my colleagues and our patients. Would they have gained access to these life saving treatments as soon in a culture that discouraged self-education? I doubt it.

The $2000 cap on education expenses is a big bad tax on learning.

It is also a big bad tax on development and innovation in healthcare.

The proposal says a lot about a culture of mediocrity within government with respect to education.

It will be bad for doctors and worse for health consumers.

The AMA has made a detailed response to the discussion paper.

You too can respond. Simply send an email to selfeducationtaxreform@treasury.gov.au. Let them know what you really think.

Other actions that every member can take are to write to their Member of Parliament or make an appointment to see them, sign on to the Scrap the Cap petition (http://www.scrapthecap.com.au/) and share your story about how the cap will affect your work and the service you provide to your patients (http://www.scrapthecap.com.au/tell-your-story/).

TO COMMENT CLICK HERE

Professions unite to oppose tax cap

The Federal Government is coming under mounting pressure to dump its controversial $2000 cap on tax deductions for self-education expenses amid a groundswell of opposition from organisations representing around 1.6 million doctors, nurses, engineers, lawyers, accountants and other professionals.

More than 50 peak professional bodies have joined the AMA in its campaign to have the tax change – due to come into force on 1 July 2014 – axed.

AMA President Dr Steve Hambleton met with the leaders of 21 other professional organisations last week to issue a united call for the Government to abandon the proposed tax cap, which he condemned as "a double dose of dumbness".

"The Government should be encouraging self-education to grow the economy, not setting up road blocks," Dr Hambleton told the meeting. "It is a tax on education that will make it much harder for doctors to develop and maintain their skills, and make it much more difficult for them to sustain world-best practice in the quality of care they provide."

The summit, convened by Universities Australia, brought together representatives from organisations including the Law Council of Australia, Engineers Australia, the Australian Institute of Management, the Institute of Chartered Accountants, Rural Doctors of Australia, the Australian Dental Association and the Australian Nursing Federation.

In a joint communiqué, the groups said the tax change was short-sighted and counter-productive, and could undermine future national prosperity.

"At a time when education has never been more important, the measure effectively imposes a tax on learning," the communiqué said. "The cap threatens Australia's ability to become a productive, innovative, contemporary knowledge-based economy. [It will] discourage people from being sufficiently prepared for the high-value jobs of a modern services and knowledge-based economy."

The Government could face parliamentary scrutiny of the tax change, after the Australian Greens flagged a call for a full Senate inquiry into the proposed measure.

Greens leader Senator Christine Milne said the tax cap would require legislation, and warned the Greens would push for the measure to be referred to a Senate committee for investigation.

"The Greens are concerned that, while the current scheme may need better targeting, the $2000 cap is a blunt instrument," Senator Milne said. "While rorting by some professions is anecdotally reported, that should not outweigh the concerns of people such as nurses from regional areas trying to get training."

The Greens leader said the tax change would be particularly unfair for professions where costly continuing education is required, and for women trying to re-enter the workforce after having children.

Dr Hambleton congratulated the Greens for taking up the issue, and called on the Government to heed the concerns of a wide range of professions and reverse its course.

So far, more than 11,000 doctors and other health workers have joined the #Scrap the Cap campaign (http://www.scrapthecap.com.au/), signing petitions, sending letters to their local MPs and sharing their stories of how the tax cap will affect their work (see box : T*he tax cap: voices from the frontline - p7*).

"The cap will make it much harder for doctors to develop and maintain their skills, and to keep up with the latest advances in knowledge and treatment," Dr Hambleton said. "Ultimately, the cost will be borne by patients, as it makes it much harder for doctors to maintain world-best practice in quality of care.

"This is why the AMA and its members take the issue so seriously, and why we are campaigning hard to make sure the cap is scrapped before it ever comes in."

Dr Hambleton said doctors in rural areas, and those in highly specialised fields, would be hit particularly hard by the tax cap, because they had no choice but to travel to attend, conferences, workshops and training courses.

So far, the Government has shown no sign of wavering from its plans, and the Opposition has accepted the cap.

Outside the AMA National Conference in late May, Shadow Health Minister Peter Dutton said that although the cap was "bad policy…it is going to be very hard to reversed this and other taxes. This is the situation we face, and it is best to be upfront on that".

Adrian Rollins

TO COMMENT CLICK HERE

The tax cap: voices from the frontline

What doctors are saying about the $2000 cap on tax deductions for self-education expenses:

As rural general practitioners it is important for us to maintain our professional skills by attending hands-on courses and workshops throughout our professional career. Unfortunately, many of these essential courses are held at major cities, requiring us to organise travel, accommodation and pay for our course fees. The fee itself for most of these courses would cost close to $2000. You may ask whether having courses done online would be just as effective. The answer is no. You cannot learn procedural skills by attending webinars.

I can guarantee that when the cap comes into being many rural general practitioners will become de-skilled due to the lack of incentive to attend good CPD activities. The result will be a significant loss of good procedural skills, ultimately leaving rural communities even more disadvantaged, as their demoralised doctors have lost the skills and motivation to provide good treatment because of a self-education cap that does not encourage a drive for excellence.

Janssen, rural GP, South Australia

I work part time as a GP with a special interest in women's health and antenatal care. I am the sole female GP in my suburb, and perform a lot of antenatal care, as the local hospital's maternity unit is massively over-stretched. I usually attend one to two weekend meetings a year [to meet] the RACGP's compulsory CPD requirements, and [to] keep up to date with current practice standards. Most meetings I attend are within a comfortable driving distance and, even without having to pay for airfares, the cost of registration and accommodation easily exceeds $2000. The current governments plan to cap self education deductions will result in doctors electing not to attend relevant updates and meetings. Subsequently, patient care will suffer. Patients will also be affected as some GPs choose to increase fees to cover these out of pocket expenses. My local area is a typical "mortgage belt" region, and a lot of local residents are struggling financially as cost of living increases, and jobs become harder to find. An increase in fees to cover my out of pocket CPD expenses will have a huge impact on my practice.

Tanya Casey, GP, Pacific Pines, Queensland

I'm delighted to be practicing as a GP in Australia moving form the UK a year ago. While experienced in minor surgery, I'd identified skin cancer management as an area I needed to cover well. While there were many excellent courses available, they cost between $2000 and $3400 per weekend and the total cost has run to around $20,000 - the bulk of which were course fees. A cap of $2000 would not have even covered the emergency medicine course I had a requirement to go on to maintain FRACGP. These are genuine professional expenses incurred in genuine education.

Pete Allamby, GP, Ocean Reef, Western Australia

I am a partner in a general practice in rural Victoria. I work as a GP, I provide hospital care, I visit two nursing homes. I have a special interest in skin cancer medicine, and I operate a full day a week in my practice, accepting referrals from other GPs to manage complex tumours. I lecture for Monash University. I am a medical educator with our GP training program.

Fortunately, my practice covers my registration ($600), indemnity ($5000), RACGP ($900) and RDAV ($350) (all approximate) fees and the GP training program covers my costs to maintain and develop my skills as a teacher of the GPs of the future. Excluding these costs, my personal education related expenses last year including travel, accommodation, course fees and expenses, and not including the cost to my practice of my time away from income generating activity, were about $9000.

I take pride in being the best doctor I can be, and in providing my patients with a high level of care. Plainly speaking, if I have to cut back on training, my patients will suffer, as I will no longer be a competent, up-to-date, highly skilled GP. But I'll save the ATO a few dollars.

Stuart Anderson, GP, Maffra, Victoria

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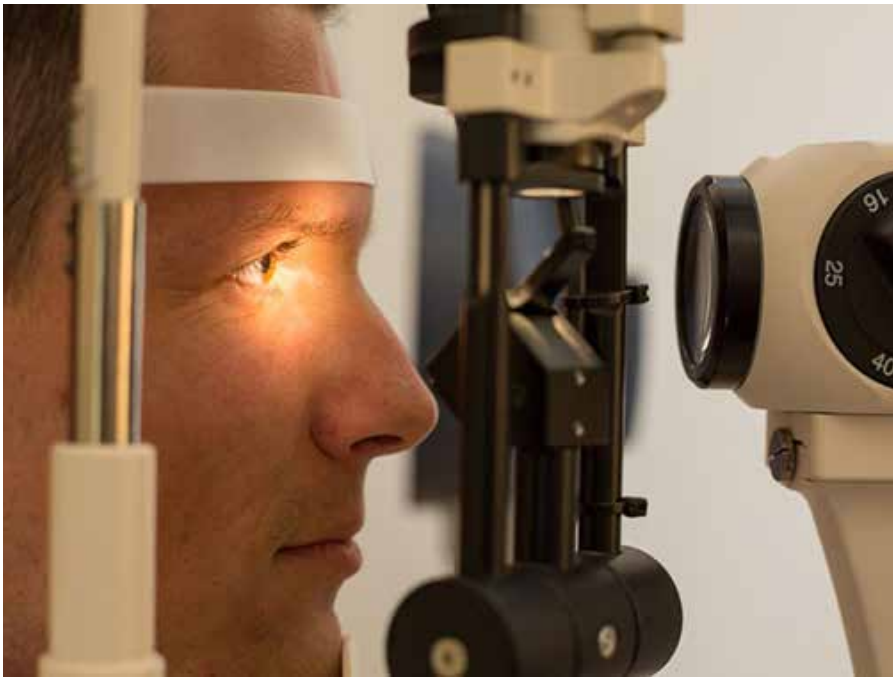
See you in court: eye doctors take on regulators



Ophthalmologists have launched legal action against medical practice regulators in an escalation of a row over the role and responsibilities of optometrists.

In a significant development, the Australian Society of Ophthalmologists (ASO) and the Royal Australian and New Zealand College of Ophthalmologists have taken the Optometry Board of Australia and the Australian Health Practitioner Regulation Agency to court to block a move to give optometrists authority to diagnose and treat glaucoma without specialist oversight.

The Society said it had taken the extraordinary step of launching the action in the Supreme Court of Queensland in order to protect patient safety and wellbeing.

"ASO holds grave concerns that patient safety will be compromised by optometrists treating glaucoma without medical and specialised supervision, and in circumstances where optometrists are not sufficiently trained to do so," ASO Chief Executive Officer Kerry Gallagher said in a 119-page affidavit filed in the Supreme Court.

The Society launched the action after the Optometry Board issued new rules allowing optometrists 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.

AMA President Dr Steve Hambleton said it was disappointing that ophthalmologists had been forced into the position of launching legal action to help safeguard the quality of care provided to people suffering glaucoma.

Dr Hambleton said the Optometry Board had got it badly wrong in deciding to expand the scope of optometrist practice in this way, and should reverse course.

"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," he said.

The ASO warned that, through its decision, the Board had overturned traditional medical practice and given approval for optometrists to assess medical conditions beyond their learning and experience.

It said that ophthalmologists study for seven years to become doctors, with a further five years of study to become medical eye specialists.

All up, they spend 12,000 hours in clinical training treating eye disease before being authorised to responsibly initiate treatment for patients.

The Society and the College said they had launched the legal action to seek a reversion back to long-standing collaborative arrangements for the treatment of glaucoma.

"There is a very real risk of inappropriate treatment of glaucoma patients by optometrists who undertake treatment outside of collaborative care arrangements with an ophthalmologist," Dr Hambleton warned.

"This is not an example of health reform. This is an example of the fragmentation of health care, which is the enemy of quality care, the enemy of efficient care, and the enemy of affordable care."

Adrian Rollins

TO COMMENT CLICK HERE

Family Doctor Week

The AMA's annual celebration of the hard work and dedication of the nation's family doctors, Family Doctor Week, begins today.

For 2013, the AMA has adopted the theme Your Family Doctor – Your Medical Home, to emphasise the vital role played by GPs at the frontline of the nation's health care system.

For most Australians, their family doctor is their first port of call when they need medical care, and Family Doctor Weeks is an opportunity to highlight the crucial work they do, and what can and should be done to make it easier to provide quality care.

This year, Chair of the Council of General Practice Dr Brian Morton and fellow Council members have made two short videos to present key issues and concerns for the nation's family doctors.

The first, released yesterday (Sunday, 14 July) highlighted issues affecting primary care and what the AMA is doing to promote and protect the interests of general practitioners.

The second, to be released on Tuesday 16 July, warns that patients may be hit with higher charges unless the Government immediately increases the Medicare rebate.

The videos can be viewed at https://ama.com.au/video/ama-home-family-doctors and https://ama.com.au/video/family-doctors-your-medical-home

Throughout the week, which runs from 15 to 21 July, AMA President Dr Steve Hambleton will discuss ways the Government can provide greater support for family doctors to allow them to continue serving their local communities.

Dr Hambleton will address the National Press Club on 17 July and officially launch the *AMA Key Health Issues for the Federal Election 2013* document, which outlines the main health concerns the AMA wants to see the political parties address in the lead-up to the Federal election due later this year.

State and Territory AMAs have also been spreading the word about Family Doctor Week to local GPs, encouraging them to speak to their local Member of Parliament about ways the Government can provide greater support for family doctors.

In addition, the AMA has produced and distributed posters celebrating the important work done by family doctors and highlighting the drop in value of Medicare rebates.

To find out more about AMA Family Doctor Week 2013, visit: https://ama.com.au/familydoctorweek2013

Kirsty Waterford

TO COMMENT CLICK HERE

Rescheduling of benzodiazepines

The AMA has successfully headed off moves to make all benzodiazepines controlled drugs, which would have added significantly to the administrative burden on GPs and hospital staff.

Under current rules, benzodiazepines are listed by the Therapeutic Goods Administration as Schedule 4 medicines, meaning they can only be obtained through prescription.

But the TGA announced last year that it was considering a proposal to reclassify all benzodiazepines from Schedule 4 to Schedule 8, making them controlled drugs and effectively prohibiting most GPs from being able to prescribe them without specific authority.

In a submission to the TGA's Advisory Committee on Medicines Scheduling, the AMA urged the medicines watchdog to carefully weigh the balance between the desire to limit the potential for abuse of these drugs on the one hand, and the imperative that they be readily available when clinical need was urgent, such as in hospitals.

The Association said, while benzodiazepines were at risk of abuse, there were currently a range of controls in place, including electronic tracking of dispensing, patient and medical practitioner education, audits of prescribing, and prosecutions.

In addition, the AMA argued, moving all benzodiazepines to Schedule 8 would create significant additional administrative burden for both hospital staff and general practitioners.

After reviewing this and other submissions, the TGA has decided that only the benzodiazepine medicine alprazolam will be rescheduled from Schedule 4 to Schedule 8.

The scheduling of all other benzodiazepines will remain unchanged.

In a statement, the regulator said it had decided to reschedule alprazolam for several reasons, including the fact that overdoses of the drug resulted in increased morbidity and mortality, there had been rapid growth in its use, and evidence was mounting of widespread misuse.

Alprazolam will be reclassified as a Schedule 8 drug from 1 February 2014.

Adrian Rollins

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

TO COMMENT CLICK HERE

AMA IN THE NEWS

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

Print/Online

Diet tea's page shut after health horrors reported, *Sun Herald*, 30 June 2013

Health and medical experts warned that the laxative effect of fad dieting product SkinnyMe Tea can cause unhealthy weight loss. The AMA said using laxative products when they are not needed causes electrolyte and fluid loss.

Shed your habit, *Sunday Herald Sun*, 30 June 2013

Smokers' shelters may be built near city hospitals to save visitors walking through clouds of smoke. The AMA said hospitals should be more active in encouraging patients and staff to quit smoking.

Doctors reap in the drug dollars, *Adelaide Advertiser*, 3 July 2013

A Medicines Australia working party suggested that drug companies should publicly record payments to doctors of more than $10. AMA Vice President Professor Geoffrey Dobb said the AMA is opposed to drug companies releasing an aggregate list of how much they pay each doctor.

Unproven therapies under fire, *Adelaide Advertiser*, 6 July 2013

AMA Vice President Professor Geoffrey Dobb said that taxpayers and health insurers should not be forced to pay for unproven natural therapies.

Low sign-up for eHealth, *Adelaide Advertiser*, 8 July 2013

AMA President Dr Steve Hambleton said the current e-health system is flawed because GPs and hospitals could not easily access and enter information in the system.

Drugs, straps used to control residents, *The Age*, 8 July 2013

There are concerns that chemical and physical restraint of dementia sufferers is used too frequently due to insufficient resources in nursing homes. Dr Hambleton agreed, and said many aged care facilities lacked the resources to provide non-pharmaceutical solutions.

White collar staff pan 'tax on learning', *The Australian Financial Review*, 9 July 2013

The AMA met with other professional groups to discuss the Scrap the Cap campaign. Dr Hambleton said the $2000 limit on tax deductions for self-education expenses would dumb down Australia.

Opposition mounts to Swan's education cap, *The Australian*, 9 July 2013

Twenty-two peak professional and educational groups said a $2000 cap on tax deductions for self-education expenses was a tax on learning should be abandoned before it takes a toll on national productivity. Dr Hambleton said the policy was poorly informed and poorly implemented.

Radio

Dr Steve Hambleton, 666 ABC, 8 July 2013

AMA President Dr Steve Hambleton discussed the Government's proposed cap on tax deductions for self-education expenses.

Dr Steve Hambleton, ABC Radio National, 9 July 2013

Dr Hambleton said safer packaging, better labelling and improved product design was needed for lithium batteries to prevent serious injuries in children.

TV

Dr Steve Hambleton, SBS, 8 July 2013

Medical groups have warned that remote Indigenous communities may be the unintentional victims of the Federal Government's savings measure to cap tax deductions for professionals who undertake self-education. AMA President Dr Steve Hambleton said self-education is more expensive for doctors working in remote areas because they have to travel large distances to attend conferences, workshops and training courses.

TO COMMENT CLICK HERE

AMA in action

AMA President Dr Steve Hambleton has been busy representing the AMA around the globe this past month, attending the Queen's Health Policy Change Conference in Canada, the American Medical Association's House of Delegates and the British Medical Association's Annual Representative Meeting.

Dr Hambleton started his trip in Canada, where he met with Dr David Walker and Dr Michael Green from Queen's University in Ontario, Canada. Dr Hambleton presented a talk about the Australian Medicare system at the Queen's Health Policy Change Conference and discussed how aspects could be adopted for a Canadian Medicare-style model of care.

Dr Hambleton then travelled Chicago attend the installation of incoming American Medical Association President Dr Ardis Dee Hoven. Dr Hambleton met World Medical Association President Dr Cecil Wilson and President-elect of the American Academy of Family Physicians Dr Reid Blackwelder while attending the conference. During his visit, Dr Hambleton stopped in at the Center for Care and Discovery - a teaching hospital attached to the University of Chicago - and attended a meeting with the Center's Executive Vice President for Medical Affairs Dr Ken Polonsky to learn about its operations.

From there, Dr Hambleton flew to Edinburgh in Scotland to attend a meeting at which the new BMA President Dr David Haslam was installed. He spoke with WMA Chair Dr Mukesh Haikerwal and Chinese Medical Association delegates, many of whom he had met recently at the Chinese Medical Association's Annual Conference. Dr Hambleton also held talks with Dr Hamish Meldrum, Immediate Past Chair of BMA, about the British health system.

Dr Hambleton arrived back in Australia ready to step up the AMA campaign against Federal Government's $2000 cap on tax deductions for work-related self-education expenses. He met representatives from more than 20 other professional organisations opposed to the cap, and took part in discussions for strategies to achieve its removal. To get the latest updates on the campaign to go www.scrapthecap.com.au or follow #scrapthecap on twitter.

Dr Hambleton also met with Dr Graeme Killer, Principal Medical Adviser to the Repatriation Commission for the Department of Veterans Affairs and discussed the AMA's strategy for the upcoming election with the AMA Executive Council.

TO COMMENT CLICK HERE

AMA Executive Council, Dr Stephen Parnis, Professor Geoffrey Dobb, Dr Steve Hambleton, Dr Liz Feeney and Associate Professor Brian Owler, meeting in Canberra on 10 July

Dr Hambleton speaks at a meeting of peak professional organisations hosted by Universities Australia to discuss the campaign against the cap on tax deductions for self-education expenses

President-elect of the American Academy of Family Physicians Dr Reid Blackwelder with Dr Hambleton

Dr Hambleton attended the instalation of the new BMA President

Dr Hamish Meldrum, Immediate Past Chair of BMA, with Dr Hambleton

Chair of the American Medical Association's House of Delegates, Dr Atul Nakhasi

Dr David Walker and Dr Michael Green from Queen's University, Ontario, Canada with Dr Hambleton

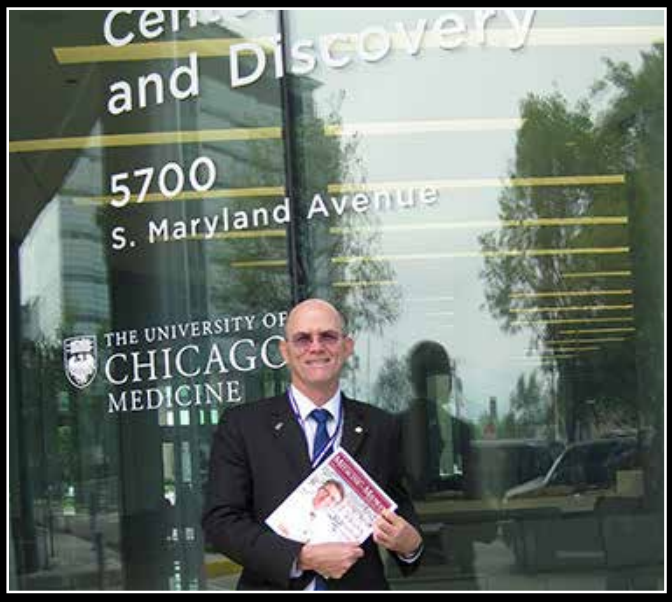
University of Chicago Executive Vice President for Medical Affairs Dr Ken Polonsky from the

Dr Cecil Wilson President of the World Medical Association

Dr Hambleton at the American Medical Association's House of Delegates

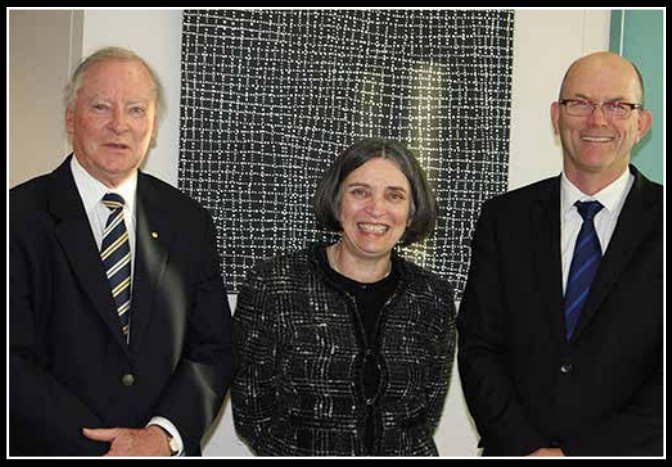
Dr Hambleton with Chair of the World Medical Association Dr Mukesh Haikerwal and respresentatives of the Chinese Medical Association

Inauguration ceremony for incoming American Medical Association president Dr Ardis Dee Hoven



Dr Hambleton outside the Center for Care and Discovery - a teaching hospital attached to the University of Chicago

Dr Hambleton speaks to the media about the cap on tax deductible self-education expenses following a summit of peak professional organisations on 8 July



Dr Hambleton with Department of Veterans Affairs officials, Chief Medical Officer Dr Graeme Killer and First Assistant Secretary Ms Judy Daniel

Dr Hambleton talks about the AMA's plans to fight the indroduction of the self-education cap

PCEHR falls short of start-up target

Registrations for e-health records have fallen well short of Government expectations as the system struggles to attract the interest of doctors and their patients.

Figures released by the Department of Health and Ageing show that in its first 12 months barely 407,000 people signed on for a personally controlled electronic health record (PCEHR) – 100,000 less than planned when the system was launched in July 2012.

AMA President Dr Steve Hambleton said that although there was significant potential for electronic records to enhance care, the PCEHR was being hampered by problems with its design and implementation.

Dr Hambleton said the AMA supported the concept of an electronic health record as a way to reliably provide key clinical information about a patient.

But he warned that, in its present form, the PCEHR fell short of what was needed, both in its design and its implementation.

"A system that allows multiple health practitioners to share clinical information about a patient is good for patients and good for the health care system," the AMA President said in a column in *Pulse+IT*. "[But], as the PCEHR has rolled out and clinical practice software has become more integrated, we are seeing significant constraints on the clinical usefulness and usability of the health record, flowing from its original design."

It has been estimated that the Commonwealth has spent $1 billion developing and rolling out the PCEHR, including $50 million allocated to Medicare Locals so they can help GP clinics become PCEHR-ready.

But Dr Hambleton said implementation had so far been flawed, with mismatches between the readiness of patients and practices to use the system causing confusion and disappointment.

"It is difficult to know where patients are being registered, and where practices are already providing PCEHR services, and to what extent the two align," he said. "A patient who has been convinced to register for a PCEHR should not be confused and disappointed by discovering their medical practice is not ready to participate."

According to Department figures, more than 4000 health care organisations and 4600 individual providers have registered with the PCEHR system, but Dr Hambleton said those practices that had begun using the PCEHR system had done so with "very little" support.

He said a clinical advisory group should immediately be appointed to improve implementation and make the system much more clinically useful.

"It is now up to the medic al profession to drive improvements so it can achieve its purpose," the AMA President said. "We need to make using the system easier, to get practices using the current system more confident in their processes and usage. There is a long way to go here.

"Clearly it's not the time to introduce non-core functions that distract us from the main task."

Dr Hambleton said that to "truly get the ball rolling" on clinical use of the PCEHR, the Government needed to consider paying doctors an incentive to complete a certain number of PCEHR records for their patients.

See also "So far, PCEHR an empty record", p22

Adrian Rollins

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Holding Back the Health Tsunami:

What We Can Learn from Health Care in America and Britain

with Dr John Goodman, Dr Jean Drouin & Dr Jeremy Sammut

We are on the verge of a crisis in public health care.

The single biggest risk to future budgets will be health costs. Unless health care can be made affordable, future generations simply won't be able to fund the escalating cost of public health. Spending on health has doubled over the last 10 years and the NSW Auditor General predicts that health spending will consume the entire NSW budget by 2033.

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Child vaccination rates alarmingly low

Researchers have found alarmingly low rates of vaccination among children hospitalised for chicken pox, highlighting warnings that parents are putting lives at risk by neglecting immunisation.

And, in a result that calls into question concerns about the safety of influenza vaccination for young children, the study - using data collected through the Paediatric Active Enhanced Disease Surveillance (PAEDS) system – found only a fraction of those hospitalised with the disease had received the vaccine.

The University of Sydney study found that just 16 out of 133 children hospitalised in New South Wales between 2007 and 2010 due to complications arising from chicken pox infection had been vaccinated, underlining concerns that pockets of low vaccination rates leave the community vulnerable to sustained outbreaks of serious diseases.

And, contradicting the widespread belief that flu vaccinations can cause seizures in children younger than five years, the study found that just 15 infants out of 122 hospitalised with flu symptoms during the period had received any vaccine in the previous week – and, of these, nine had underlining chronic disorders that could cause seizures, such as prior diagnosed epilepsy or viral infections.

The researchers noted that bowel obstruction was more frequent among infants receiving the first, rather than second, dose of either of the two available rotavirus vaccines.

Surveillance during the influenza pandemic in 2009 found that swine flu was the cause of 84 per cent infant hospitalisations during the period, whereas seasonal influenza was responsible for just 7 per cent.

The study revealed "only 11 per cent of all children, and 17 per cent of children with underlying chronic disorders, had been vaccinated for seasonal influenza."

Of the 324 children who had been hospitalised in New South Wales' three children's hospitals during the swine flu outbreak, complications occurred in 34 per cent – half of whom had previously been healthy.

> "Well-meaning parents are being fed dangerous misinformation which undermines their faith in the safety of vaccines. This has to stop"

The study's senior author, Professor Elizabeth Elliot, said the PAEDS research was intended to help cover gaps in surveillance data for severe vaccine-preventable diseases and unpleasant events following the immunisation.

She said that although there were "excellent national laboratory and public health surveillance systems currently operating in Australia, " very few provided well-timed, detailed clinical data.

She said this was particularly the case when it came to infectious diseases such as chicken pox, influenza and rotavirus, none of which were "readily or completely described by existing surveillance systems".

The PAEDS study findings highlight concerns about the dangers of low vaccination rates in pockets of the community.

Late last month the Senate passed legislation calling for the anti-vaccination group Australian Vaccination Network – which is fighting a rearguard action in NSW courts to block Government attempts to force it to change its name – to disband.

Australian Greens Senator Richard Di Natale has accused the AVN of carelessly spruiking unfounded claims about the safety of vaccines.

"I have had people contact me who have lost children to diseases that have a safe and effective vaccine," he said. "Well-meaning parents are being fed dangerous misinformation which undermines their faith in the safety of vaccines. This has to stop."

Well-known immunologist Professor Christopher Parish from the John Curtain School of Medical Research said late last month that vaccinations had been proven to be enormously effective in reducing the amount of people catching life-threatening diseases.

Professor Parish said long-term population health data from the United States showed a 100 per cent fall in the occurrence of major diseases such as polio and rubella between the pre- World War II period and 1995.

Professor Elliot said PAEDS had the potential to quickly identify serious emerging disease outbreaks, as demonstrated during the swine flu pandemic.

She said PAEDS was also "the first system to reliably capture data on adverse events resulting from vaccination and requiring admission."

Jeremy Mole

TO COMMENT CLICK HERE

Lawyers called to stump scammers

A Queensland medical practice has been forced to threaten legal action in the face of escalating demands for payment from purported directory services after the consumer watchdog refused to intervene.

In the latest example of directory scams targeting the health industry, Doctors @ Wellington Point practice in Queensland has paid out more than $2200 for directory listings it did not ask for, and is resisting demands for payment of a further $2995.

Practice manager Shenae Trotter told *Australian Medicine* that since the start of the year the business had received demands for payment from three organisations claiming to operate directory services.

Ms Trotter said the practice paid $1094.50 to a group called the Corporate Directory of Australia and $2194.50 to the Australian Telephone Directory, but had baulked when it received a demand for $2995 from an organisation called Business Indigenous & Government (BIG) Pages.

"The first two [claims], we just paid them, because we thought we must have done something [to warrant receiving the invoice], even though we never saw any advertising," she said. "We didn't realise anything about these scams until the Medicare Local sent out an alert."

In May, AMA President Dr Steve Hambleton alerted AMA members about a similar scam in which medical practices were being charged up to $5200 for listing in the Australasian Health Professionals Directory.

Under the scam, practices were initially approached to update their details in the directory without an upfront charge. But the fine print of the contract stipulated that listing cost $1300 a year for a minimum of three years.

Dr Hambleton warned that this was a well-established strategy used by scammers to mislead recipients and con them into signing the enclosed contract, before then making demands for payment.

The AMA President advised practices that received material spruiking the Directory to ignore it.

In addition to informing its members, the AMA has also alerted the Australian Competition and Consumer Commission as well as Fair Trading offices in each State and Territory.

Ms Trotter said that when the practice contacted the ACCC about the matter, it simply advised it to engage lawyers.

She said that after practice refused to pay BIG Pages it received a stream of threatening faxes and emails threatening legal action.

But Ms Trotter said this stopped abruptly after the practice engaged its own lawyers, who sent a strongly-worded letter challenging claims of liability and threatening to refer the matter to the Australian Federal Police "if you continue to harass our staff".

"Your repeated harassment and threats to our staff constitute bullying and breaches of other laws, including of *Crimes Legislation Amendment (Telecommunications Offences & Other Measures) Act (No. 2) 2004*," the letter said. "Do not send any further correspondence to us, or call our offices."

The lawyers have instructed Doctors @ Wellington Point staff to cease all communication with BIG Pages.

Adrian Rollins

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Running for a reason

More than 150 medical students took time out from last week's Australian Medical Student Association National Convention to participate on the Gold Coast Airport Marathon festival to raise more than $21,000 for Indigenous health services.

The runners were among 1000 medical students from across Australia who descended on the Gold Coast on 7 July for the week-long AMSA Convention, and added the annual Run for a Reason event - organised by a group of enthusiastic medical students from across Australia every year – to their itinerary.

Students of all athletic abilities took part in the Run for a Reason event, participating as individuals and as part of a team, and covered distances ranging from 5.7 kilometres through to the full 42.2 kilometre marathon.

The team of medical students who organise Run for a Reason use the event to help make a difference by improving access to health care in rural Australia.

All the funds raised from this year's event were donated to the Tharawal Local Aboriginal Land Council, which is working on a community heath project supporting

Indigenous Australians.

More information about Run for a Reason can be found at: www.runforareason.org.au.

Jeremy Mole

TO COMMENT CLICK HERE

Specialists sign up to Indigenous initiative

The nation's specialist medical colleges will upgrade their curricula and identify Aboriginal medical trainees under a landmark agreement struck with the peak body of Indigenous doctors.

The Australian Indigenous Doctors' Association (AIDA) and the Committee of Presidents of Medical Colleges (CPMC) have signed a Collaboration Agreement that includes measures to support the training of Indigenous practitioners and to improve the ability of all doctors to work competently with Aboriginal and Torres Strait Islander people.

AIDA Chief Executive Officer Romlie Mokak told *Australian Medicine* that the Agreement was one of a number of formal partnerships recently developed by his organisation with peak medical education and training organisations.

The announcement came as the nation's governments missed a deadline to renew their commitment to closing the health gap between Indigenous Australians and the rest of the community, heightening concerns that recent gains made will be squandered.

The nation's first $1.6 billion, five-year National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes expired in 30 June, and so far only the Commonwealth and Victoria have committed to a new five-year deal.

The failure of the many of the states to so far commit to a fresh Closing the Gap plan has come amid signs that an increasing number of Indigenous students are training to become doctors.

AIDA estimates there are currently around 175 Indigenous medical graduates and 300 Indigenous medical students.

Mr Mokak said that in the last two years Indigenous students had comprised 2.5 per cent of all medical school admissions, putting them at parity with their presence in the broader population.

> "Support for graduates at the junior doctor level is critical, [and] we want more people to know about pathways in specialist areas"

"That would have been unheard of 10 years ago," he said. "Over the next three to four years, as people graduate, we will see a steady rise in the number of Indigenous graduates."

But Mr Mokak said increase in graduate numbers alone was not enough, and had to be accompanied by improved support for Indigenous students through pre-vocational and vocational training.

"Our focus is the whole continuum. We are not focused on a particular level of training or particular specialty," he said. "Support for graduates at the junior doctor level is critical, [and] we want more people to know about pathways in specialist areas."

CPMC Chair Professor Kate Leslie said Aboriginal and Torres Strait Islander doctors were "significantly under-represented" in the medical workforce, and all 15 specialist medical college Presidents are committed to leading the change with our partners AIDA".

Under the Agreement, the Colleges will collate data on the number of Aboriginal trainees and practitioners within their ranks, and every year each College will send either its President or Chief Executive to spend time at an Indigenous health service, to gain first-hand experience of the conditions and challenges faced.

Mr Mokak said that, just as important as encouraging more Indigenous people into medical training was efforts to improve awareness of Indigenous culture, society and outlook among the broader medical community.

To help achieve this, AIDA is working with each College to upgrade their curricula by "providing guidelines for each speciality of things in the training of your Fellows which we would think would be necessary to know," he said.

Mr Mokak said these initiatives could serve as an example of how to achieve improvements across a wide range of areas, not just medicine.

"If we get this agenda right in medicine, we are sending a significant message to the rest of the health system that if doctors are able to tackle these issues, it should be the same for all health professions, and all professions more broadly," he said. "We see this as not only important work for medicine, but important work for the whole country."

Adrian Rollins

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INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

TO COMMENT CLICK HERE

Many ignoring life-saving test

Bowel cancer screening rates are slipping despite evidence that early detection of abnormalities can save lives.

Little more than a third of the 930,000 people offered a bowel cancer test in 2011-12 took part in the screening program, underlining calls on the Government to intensify its efforts promoting the scheme.

A report by the Australian Institute of Health and Welfare found that 35 per cent of those invited to take part in the National Bowel Cancer Screening Program in 2011-12 completed a screening test for analysis, compared with 38 per cent in the preceding three years.

The Institute found that participation declined across all three age groups eligible at the time – 50, 55 and 60-year-olds, though the Government has since expanded the program to include 60-year-olds as at 1 July.

Of those who did take part, 7 per cent (about 22,500) returned test results showing bowel abnormalities that required follow-up assessment.

Of these, 72 per cent underwent a colonoscopy, leading to diagnosis of confirmed or suspected cancer in 404 cases, with advanced adenomas (potentially cancerous growths) identified in a further 857 cases.

Bowel cancer is one of the nation's biggest killers, accounting for an average 80 deaths a week, though treatment can be effective if the disease is detected early enough.

The Government expects that 5.4 million people will be offered a free screening test under the expanded program in the next four years including, from 1 July 2015, 70-year-olds.

But Cancer Council Australia Chief Executive Officer Professor Ian Olver said Government was taking too long to fully implement a comprehensive screening program, and lives were being lost as a result.

"People who are not eligible for the program but should be, and those who are but don't take the test, are dying unnecessarily," Professor Olver said.

He said that although the gradual expansion of the program was welcome, it was taking too long and was people were deterred because of uncertainty about eligibility.

"We're pleased the Government has boosted its communications to support the program this financial year, including funding a campaign Cancer Council will run," Professor Olver said. "However, the confusion caused by the limited eligibility will continue to be a problem. What we need is a plan for full implementation from the next Australian Government."

Adrian Rollins

TO COMMENT CLICK HERE

High rates of STDs among children in detention

Alarm has been raised about the health of children being held in immigration detention following evidence that many have been infected with sexually transmitted diseases.

Prominent child psychiatrist and AMA member Dr Choong-Siew Yong warned immigration officials last year that there were "high rates of sexually transmitted infections among UAMs (unaccompanied minors)", according to documents obtained by *The Australian* under Freedom of Information laws.

The warning from Dr Choong-Siew was contained in the minutes of a briefing made by the-then Detention Health Advisory Group in May last year, *The Australian* said.

According to the minutes, Dr Choong-Siew said there was an "apparent lack of a consistent approach to child protection across the immigration detention network".

"In addition, staff appeared not to have a clear understanding of child protection procedures, including in relation to clients being transferred into community detention."

The AMA has consistently raised concerns that detention puts the health of immigrants – particularly children – at risk, and has called for the appointment of an independent group of health experts empowered to inspect detention centres and report directly to Parliament.

A separate report obtained by *The Australian* under FOI laws indicated there were 18 confirmed cases of HIV among asylum seekers since August last year, when tests for the disease were included as part of standard health screening.

The report found that, while diagnoses of HIV had jumped in the second half of 2012, at the same time the incidence of threatened and actual self-harm had plummeted, from 778 cases in 2011-12 to 96 cases between last July and December.

According to the documents, officials attributed the decline to improved mental health training for detention centre staff, a reduction in the average time spent in detention, and the use of community detention options.

Adrian Rollins

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So far, PCEHR an empty record

BY **ASSOCIATE PROFESSOR DAVID GLANCE, DIRECTOR OF THE CENTRE FOR SOFTWARE PRACTICE, UNIVERSITY OF WESTERN AUSTRALIA**

This article was first published in The Conversation on 3 July 2013, and can be viewed at: http://theconversation.com/is-the-governments-missed-health-record-target-meaningful-15558

The government has failed to meet a self-set target of 500,000 registrations of its Personally Controlled Electronic Health Record (PCEHR) by 1 July.

As at 30 June, the Department of Health and Ageing said that total number of users was 397,745. The majority of these registrations resulted from a recent push by DoHA using consultants to sign people up at public hospitals and at e-health roadshows.

Still, even if the government had met the target of 500,000, it would have been a meaningless gesture. The vast majority of those who have signed up, if they ever get around to logging in, will be greeted with an empty record.

Given the lack of active participation on the part of GPs, as well as the lack of public hospital systems to integrate with PCEHR, there's little evidence to suggest that this is going to change any time soon.

So far, only 4,805 individual providers have signed up to access the PCEHR portal. This is despite the fact that the government provides incentives to GPs to connect to the system by paying them the Practice Incentive Payments for eHealth (ePIP).

Despite these payments, GPs still struggle to see the benefit of spending time curating shared records when the legal liabilities are still unknown but are potentially severe.

The cost of the ongoing maintenance of these largely empty records is about AUS$80m a year. And that's just the baseline. It's clear that a great deal more funding will be needed to try and lift the level of meaningful use of PCEHR.

The problem for governments is that increasing spending on a system becomes progressively harder the longer it remains largely unused. What's more, the devolved nature of the Australian health system makes it extremely unlikely that we'll ever see true and meaningful use of the system.

What we will continue to see however, are reports of increasing numbers of registrations, data about the number of people who accessed the system and how much administrative data has been added.

The latter figure, in particular, is an easy one for the government. All Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data gets added automatically. This shows when individuals have claimed anything on MBS or filled out a script at the pharmacist.

Again, this data is clinically meaningless and of marginal benefit to an individual. Its only use is for, perhaps, reminding people when they last saw their doctor.

In the United States, President Barack Obama initiated a program to provide physicians with incentives to adopt electronic health records. By May this year, 55 per cent of eligible office-based providers (291,325) had received nearly US$5.9 billion in payments for adopting electronic health records.

But even there, only 27 per cent of doctors having a electronic health record actually met the core objectives of meaningful use criteria for the system. At least the criteria for defining what meaningful use means are far more stringent in the United States than the simple user registration count being used by the Australian Department of Health and Ageing for PCEHR.

As I have argued before, it's possible that we will see some benefits come from infrastructure that has been developed as part of PCEHR. Things such as individual health identifiers, for example, may eventually make identifying patient test results less prone to error.

In the meantime, we are a considerable way off seeing any clinical benefits from PCEHR. Indeed, we could question whether there are not better things within the health system that the nearly AUS$1 billion spent so far on PCEHR could have been spent on.

For the time being however, empty PCEHR records like my own will stand as testament that getting through the registration for the record is as devoid of meaning as its content.

TO COMMENT CLICK HERE

A rewarding career as a family doctor

BY **DR BRIAN MORTON**

"In 2012, almost half of all GP trainees were completing their general practice training through the longer rural pathways. This is indicative of how the profession responds to the needs of the community."

This week is Family Doctor Week 2013, and the AMA will be celebrating the hard work and dedication of the nation's family doctors – the GPs who serve local communities in the cities, country towns and remote areas of Australia.

The family doctor is, and must remain, the foundation of the health system.

Ensuring a general practice workforce for the future will be, in my view, a key issue.

It is widely acknowledged that there are shortages in Australia's medical workforce, particularly in outer metropolitan, rural and remote areas. It is predicted that that by 2025 there will be a shortage of 2700 doctors.

Currently in regional and rural Australia there simply are not enough general practitioners.

While metropolitan areas have 124 GPs per 100,000 head of population, in inner regional areas there are only 106, and only 99 in outer regional areas.

In addition, general practices - particularly in regional and rural areas - are heavily reliant on International Medical Graduates to sustain their existing workforces, and this is expected to remain the case through to at least 2025.

To help relieve this shortage, the Government has increased the number of medical student places available at university medical schools.

However, significant bottlenecks are developing in medical training due to projected shortages in training places beyond medical school – at the intern, prevocational and specialist (including general practice) training levels.

It is vital that the next Government ensures there are enough GPs to meet the health care needs of the population.

The increased number of medical students need quality experiences in general practice, and access to training places that will enhance knowledge and build the skills of the next generation of GPs. The Government can contribute by:

- increasing the Practice Incentive Payment for teaching medical students to $200 per teaching session, so that it better reflects the costs to general practice of teaching medical students;
- committing to the ongoing funding of at least 100 intern places a year in expanded settings, including private hospitals;
- increasing the number of places in the Prevocational GP Placements Program to 1500 places a year by 2016, and to 1700 places a year by 2019, supporting more junior doctors to have a quality general practice experience; and
- increasing the GP training program intake to 1500 places a year by 2016, and to 1700 places a year by 2019.

On the subject of training, the 16th report of the Medical Training Review Panel (MTRP) reminds us all of the extensive training (10 to 14 years) required to become a general practitioner.

Those doing the most will generally work in rural practice, which requires advanced training.

In 2012, almost half of all GP trainees were completing their general practice training through the longer rural pathways. This is indicative of how the profession responds to the needs of the community.

While more training places are part of the solution, addressing GP shortages - particularly in rural areas - will require a comprehensive approach that includes appropriate incentives, professional support, and takes into account the needs of a GP's family members with respect to access to education and other family needs.

The AMA's Key Health Issues for the 2013 Federal Election document, launched this week, further outlines the AMA thinking on this score.

And of course, we could do without a great big new tax on learning that both sides of politics seem committed to at this point.

This will also be an election issue for the AMA.

TO COMMENT CLICK HERE

Better remedies needed for student distress

BY **AMSA PRESIDENT BEN VENESS**

Just before lunch one recent Sunday, I walked with a friend I hadn't seen in a couple of years. We spent a while talking about his semester on exchange in Switzerland and subsequent travels through Europe, and then moved on to discussing why he's applying to medical school for 2014.

I chuckled when his face lit up while talking of his post-GAMSAT hospital admission, for appendicitis (GAMSAT is the admissions exam for graduate-entry medical programmes). He spoke eagerly of how interesting his three days in the ward had been, and of all the questions he had been able to ask his doctors.

We moved on to discussing my experience of medical school, and I remarked how lucky I thought we were to be learning such interesting material and gaining an expedited, vicarious life experience through the patients and families we meet. The exposure we get is startling, which I mean mostly as a good thing.

It can, however, also be confronting. For most of us, we eventually find at least one of the patients we meet has a story that hits close to home. I remember being particularly distracted in first year by a patient my examination skills group met while practicing something or other.

Mysteriously, this very acquiescent young man had trouble speaking, and something called a PEG tube sticking through his abdomen. It transpired that he had taken a deliberate drug overdose and then suffered damage to his vocal cords during a botched intubation attempt.

In addition to not being able to speak properly, he could now neither eat nor drink, and a return of function was purely hypothetical.

He would soon be discharged and yet, despite maybe never again being able to share a drink or a meal with his friends, we hoped he would not attempt suicide again.

His face has faded in my memory, but as I write this I still empathise and wonder how he is doing now. There are students for whom this experience might have hit even closer to home.

The dearth of epidemiological data specific to the Australian university context is a deficiency AMSA would like to see addressed, but a recent survey of 30,000 students in Canada, reported in *The Globe and Mail*, revealed that 9.5 per cent had seriously considered taking their own lives in the past year, while 1.3 per cent said they had attempted suicide.

A study of University of Adelaide students, conducted across various faculties in 2010, found that 44 per cent of medical students were classified as psychologically distressed.

This was similar to the rate (48 per cent) the authors found for all students surveyed, which was noted to be 4.4 times that of age-matched peers. If these numbers are accurate and broadly representative, then they are startling.

Improved mental health services for students are a priority for AMSA, which earlier this year adopted the *Student Mental Health and Wellbeing Policy.*

The issue features prominently in our Federal Election strategy, and – through Universities Australia – we are making sure the nation's chancellors and vice chancellors are aware of our concerns.

In addition, the National Executive has established two small project teams to help it address this important but somewhat neglected issue: one to document the student mental health services provided by universities across the country, and the other to plan our strategy to push for improvements.

Emphasising the importance AMSA attaches to the issue, we have made mental health the theme of the first edition of our biannual magazine, *Panacea*, for 2013.

We are particularly grateful for the contributions we received from those students who were brave enough to share their personal experiences.

It's heartening to read, in some of these stories, of the wonderful support provided to colleagues in need.

Reducing the stigma around mental illness is a crucial step towards improved access to care and enhanced quality of life.

I hope we all take heed of their example and pay careful attention to the wellbeing of ourselves, and others.

After all, it is in patients' best interests that doctors be healthy, too.

Benjamin Veness is the president of the Australian Medical Students' Association. He is studying medicine and a Master of Public Health at The University of Sydney. Follow on Twitter @ venessb and @yourAMSA. Panacea is available from AMSA's website, amsa.org.au

TO COMMENT CLICK HERE

A great idea lost in translation

BY **DR DAVID RIVETT**

"... given that all parliaments are blighted by an over-representation of the legal profession I, for one, won't be holding my breath"

The National Disability Insurance Scheme that is coming into being as DisabilityCare Australia is nothing remotely like the original 'no fault' scheme embraced by the AMA.

Sadly, the much-anticipated diversion of funding from avaricious legal firms to those in need will not occur.

Even if the disabled party chooses not to sue another party for damages, this may be overridden by National Disability Insurance Scheme (NDIS), and damages sought on their behalf.

Worse still, if the action is lost, costs can be subtracted from the benefits that the party is entitled to receive.

A win-win situation for lawyers who will be guaranteed a payday, win or lose in court, but what of the disabled party?

Recently, I had a male patient in his fifties who was badly injured when a 4WD driver on the wrong side of the highway totalled his car.

He finally received compensation after years of wrangling – he ended up with less than $100,000, while the legal costs arising from the case and paid for in the judgement were far greater. Hardly a good outcome, yet all too common.

So is all lost? Will we never see a 'no fault' scheme where benefits are determined by expert panels without massive legal expenditure?

The answer to this lies in the hands of the states.

They have the power to determine the disabled parties' rights to financial redress via the legal system.

One can but trust they will look at the sum total expenditure and determine if insurance dollars are better spent on the disabled, or in the courts.

However, given that all parliaments are blighted by an over-representation of the legal profession I, for one, won't be holding my breath.

And for those of you who are 65 years of age and in the NDIS, there is a threat that the Chief Executive Officer, in trying to keep costs down, will strongly encourage you to leave the Scheme and enter the aged care system.

Just ensure you don't have a cerebral vascular accident after 65, because you won't be able to enter the disability system and will have to rely solely on the overstretched aged care system for support.

I love the concept of the Scheme, as a mark of our society's humanity, but what is proposed has lost the plot.

TO COMMENT CLICK HERE

Thought provoking to the end

BY **DR LIZ FEENEY**

The 2013 AMA National Conference Policy Discussion Session *Finding Ways to Provide the Best Possible End of Life Care* proved to be both thought provoking and confronting for delegates, members, and other participants. We couldn't have wished for a better outcome.

Led by the session Chair Professor Paul Komesaroff, speakers Dr Peter Saul, an intensive care specialist, Dr Kate Robins-Browne, a general practitioner and PhD student, and Professor Michael Ashby, a palliative care physician, gave frank and honest accounts of their experiences, views, and concerns in relation to the role of the doctor in end of life care.

I've taken the liberty in this article of highlighting what I believe are some of the most salient points raised during their presentations:

1. the health care system doesn't respond well to the needs of those who are dying. There are several reasons for this. The demographic at the end of life has changed in the past few generations – we used to die from sudden deaths but now we predominately die much more slowly from chronic disease, usually in the acute care setting of a hospital (often including multiple hospital admissions);

   As such, the experience of dying, and the experience of family members and others who support patients during the process, can be long and drawn out. While doctors predominately address the biomedical aspects of dying, there are other aspects of dying experienced by the individual including emotional, psychological and existential aspects;

2. due to this multi-faceted nature of dying, we need to acknowledge that death is not primarily a medical event. The medicalisation of death may be convenient, particularly as it includes the idea of controlling death. The current emphasis on patient autonomy encompasses the idea of control of the dying process. But autonomy is not a moral imperative, it is not universal, and not everyone wants to participate this way at the end of life;

> "The demographic at the end of life has changed in the past few generations"

3. for those who do embrace the concept of patient autonomy, the actual application of autonomy to end of life care is grossly oversimplified, as few patients have the capacity to make their own decisions at the end of life. While advance care planning, including the use of advance directives, is promoted as a means of supporting patient autonomy when one loses capacity, directives are often non-existent, unavailable, not sought, or not applicable to the circumstance at hand - particularly in acute care. Directives can also be problematic in that they can be burdensome, preferences change, and they can cause tension and disruption in the relationship between the patient and their family members. While advance care planning is certainly valuable and should be encouraged, it is by no means a single solution to improving end of life care and supporting patients' wishes;
4. what is needed to provide better end of life care? We need to recognise that the barriers to improving decision-making and care at the end of life are not just, or even primarily, medical – they include social, ethical, religious, and political considerations of death and dying. Dying means different things to different people;
5. we need to engage the community in talking about death. As a society, we don't acknowledge and prepare for death the way we used to in the past. Dying should be recognised, acknowledged, supported by all parts of the community, and palliative care should be given timely and appropriate provision for those who need it. A lot of end of life discussions and decision-making, including advance care planning, can be done in primary care, but the issue of Medicare reimbursement for these activities needs to be addressed;
6. while death may be primarily about comfort and dignity at the individual level, there are ecological and economic dimensions to death that are unavoidable; and
7. death is not an ethical dilemma, it just is.

Personally, I found this policy discussion session to have been invaluable, and greatly appreciate the time and effort the speakers put in to engaging our members on a difficult issue - but one we will all face, whether professionally or personally, during our lifetime.

Members can view the session on the AMA's website at https://ama.com.au/live (select 9am to 10:30am session on Saturday 25 May 2013).

TO COMMENT CLICK HERE

Improved dementia care a priority

BY **DR RICHARD KIDD**

It is with great pleasure that I have accepted the President's invitation to chair the AMA Committee for Healthy Ageing.

I want to pay tribute to Dr Peter Ford, who has chaired the committee since 2006. Peter has been tireless in his efforts to secure better arrangements for providing medical care to older Australians outside the doctor's surgery. He has made himself available to represent the AMA and its members' interest at countless Government and industry committees on aged care, and to advocate for the most vulnerable members of the Australian community. It is fitting that Peter was awarded the President's Medal at the recent AMA National Conference.

In his last *Australian Medicine* column as Chair of the Committee, Peter highlighted the clinical issues that the AMA put to the Senate Community Affairs Committee inquiry into the Living Longer Living Better package of Bills. Unfortunately, the Committee did not see fit to consider the AMA's recommendations about clinical issues within the context of the aged care reforms.

On a brighter note, the House of Representatives Standing Committee on Health and Ageing report *Thinking Ahead: Report on the inquiry into dementia: early diagnosis and intervention* makes several recommendations related to medical care that the Committee for Health Ageing will need to develop responses to.

These include:

- Improved general practitioner education and the development of best practice guidelines for the diagnosis of people with intellectual disability, as well as guidelines for the care of dementia patients (recommendations 2, 3 and 10);
- The implementation of programs for early and timely diagnosis in regional, rural and remote areas using multidisciplinary teams; streamlined local referral pathways for dementia diagnosis, treatment and support; and evaluation of a nation-wide multi-disciplinary approach to dementia diagnosis, treatment and support (recommendations 8, 11 and 12);
- a review of the Medicare Benefits Schedule to support the assessment and management of dementia in primary care (recommendation 7); and
- the development of toolkits and guidelines for medical practitioners on planning options for dementia patients (recommendation 6).

The Senate Community Affairs Committee inquiry into the care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia is due to report on 12 August 2013.

It will be interesting to see if they come to the same conclusions as their parliamentary colleagues in the other chamber, particularly regarding recommendation 7, which was the main focus of the AMA's submission to the Senate inquiry.

AMA responses to the outcomes of the two inquiries, and the response of whoever is in government following the forthcoming election, will certainly keep the Committee for Health Ageing occupied over the next year.

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Australian Medical Association Limited ACN 008 426 793 ABN 37 008 426 793

Invitation for nominations for election to Federal Council as Craft Group Nominee

Following the outcome of the 2013 election for the positions of Chair of Council and Treasurer, pursuant to the Articles of Association, nominations are now invited for election to the Federal Council of one Ordinary Member as a Nominee of each of the following Craft Groups:

- Anaesthetists
- Ophthalmologists

1. Nominees elected to these positions shall hold office until the conclusion of the May 2014 AMA National Conference.
2. A nominee must be an Ordinary Member of the AMA and a member of the relevant Craft Group for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Craft Group for which the nomination is made.
5. Nominations should be addressed to the Returning Officer (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than 5.00pm Wednesday 17 July 2013.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words. Such statement will be circulated with the ballot paper if it is approved by the Federal Council.

For a copy of a nomination form or any general enquiries please contact Ms Nadene Sharpe, Office of the Secretary General and Executive (email: nsharpe@ama.com.au).

Mr Warwick Hough
Company Secretary
1July 2013

Health on the hill

Political news from the nation's capital

Labor leadership change pushes research to top table

Medical research has been elevated to a Cabinet-level issue as part of the fall-out from Labor's tumultuous leadership struggle.

In a reshuffle following his re-election as Labor leader, Prime Minister Kevin Rudd expanded the responsibilities of Health Minister Tanya Plibersek to include medical research.

The move is viewed as part of a broader strategy by the Rudd Government to directly challenge the Opposition across a range of policy areas.

Last month the Coalition seized the initiative in medical research, releasing an election policy pledging to shield the National Health and Medical Research Council (NHMRC) from budget cuts and drawing on the findings of the McKeon Strategic Review of Health and Medcial Research to promise longer research grants that are simpler to apply for.

The expansion of Ms Plibersek's portfolio is seen as an attempt to beef up Labor's credentials in the medical research area ahead of the Federal election.

Ms Plibersek said she was "delighted" to become the nation's first-ever Minister for Medical Research, and the Government's commitment to research was underlined by the fact that the NHMRC's annual funding allocation would increase from $802 million to $814 million over the next four years.

But the AMA has urged the Minister to use her expanded Cabinet role to convince the Government to adopt the McKeon Review's recommendations and drive further investment in medical research.

In a letter to Ms Plibersek following her re-appointment to Cabinet, AMA Vice President Professor Geoffrey Dobb congratulated the Minister on her enlarged portfolio, which he said should be used to enhance the nation's research capacity.

Professor Dobb said that although the Government had increased medical research funding, "much more needs to be done".

He said the AMA endorsed the outcomes of the McKeon Review, and believed it was essential to boost support for medical research if the nation was to "gain the maximum benefit from the expertise that exists in our hospitals, universities and community".

"The AMA would strongly encourage you to adopt the Review's recommendations, including in the suite of policies you take to the upcoming Federal election," Professor Dobb said. "A robust program of health and medical research is essential to an efficient and properly functioning health system."

The AMA Vice President said the country's relative prosperity and proven record of innovation meant, "we should be aiming to be an international leader in investing in health and medical research".

Adrian Rollins

TO COMMENT CLICK HERE

Employers recruited to encourage enrolments

The health sector is at the centre of an Australian Electoral Commission drive to enrol almost 1.5 million people it believes are missing from the electoral roll.

With the next Federal election due by the end of the year, the Commission has called on employers, particularly in industries such as health care - where many young adults work - to help encourage their staff to enrol to vote.

Electoral Commissioner Ed Killesteyn said it was estimated that around half a million people between 18 and 24 years of age had not yet registered to vote.

Mr Killesteyn said most in this age group were working, particularly in health care, hospitality, retail, construction and clerical jobs, and workplaces were an important way to get the enrolment message out to them.

"Workplaces can play a valuable role in encouraging employees to enrol now and not leave it to the last minute," he said. "A healthy democracy is one in which all eligible Australians exercise their right to vote, [and] the first step is making sure your name is on the electoral roll."

Employers can register to have a kit of materials to encourage enrolment sent to them by visiting www.aec.gov.au/register

Adrian Rollins

TO COMMENT CLICK HERE

Health on the hill

Political news from the nation's capital

Election focus on primary care

The Federal Government has sharpened its pitch to the primary health sector ahead of the Federal election, boosting funding for research and outlining plans to shift it to the centre of national health policy.

Health and Medical Research Minister Tanya Plibersek told the Primary Health Care Research Conference in Sydney last week that the Government was intensifying its support for primary care as a way to improve the nation's health and make most effective use of limited health funds.

"This Government is shifting the gravity in the Australian health system towards primary care," Ms Plibersek told the Conference. "Primary health care is critical to Australia's health system because it helps keep people well and out of hospital. The better we are at primary care, the better for patients and for our system."

The Minister's comments came after Shadow Health Minister Peter Dutton flagged last month that an Abbott Government would shift the health policy focus of the Commonwealth away from hospitals and on to primary care.

At the Conference, Ms Plibersek announced $2.5 million would be contributed to the creation of an international primary health care research organisation, in partnership with Canada.

She said the organisation would bring together more than 20 researchers, clinicians and policymakers from both countries, and have as its research focus chronic disease prevention and management, as well as improving access to primary health care for the vulnerable in the community.

"This is a natural partnership given the similarities between our two countries economically, demographically, and in terms of health challenges like chronic disease and ageing populations," Ms Plibersek said.

The Minister said the National Health and Medical Research Council would also be given $11 million to fund research on primary health care capacity and infrastructure, improved consultation and participation, integrated care, performance measurement and e-health.

In an attempt to sharpen differences in health policy between the Government and the Opposition, Ms Plibersek emphasised the central role she expects Medicare Locals increasingly to play in supporting primary care.

The Coalition has adopted a sceptical approach to Medicare Locals, though in recent weeks it has vacillated on earlier statements that it would shut them down if it wins government.

In pointed remarks, Ms Plibersek underlined the Government's commitment to the Medicare Locals system, which has been showered with $1.8 billion of Commonwealth funding.

"All of this research will provide strong evidence to help Medicare Locals further improve their coordination and delivery of primary health care services at the community level," she said.

"As a Government, we have looked at the research on primary care, [and] central to that action has been the establishment of Medicare Locals.

"Medicare Locals are a key part of the Government's health reform agenda.

"We see Medicare Locals as the newest part of Australia's universal health system, not an optional extra."

The Government hopes to cement the place of Medicare Locals with the support of the State and Territory governments.

To this end, Ms Plibersek announced last week the creation of the National Health Care Strategic Framework, which she hailed a s a "step in the ongoing process of…cultural change in our health system".

"It's a statement of our intent as Australian governments to continue to work together to create a stronger, more robust primary health care system."

Ms Plibersek said the framework had as its strategic priorities the construction of a patient-focused and integrated primary care system; improving access and reducing inequity; increasing the focus on health promotion and prevention; and improving safety, quality and accountability.

"The Federal Government is now working with each State and Territory to develop state-specific plans for implementing the framework," the Minister said.

Adrian Rollins

TO COMMENT CLICK HERE

Members' Forum

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

People who turned 60 years earlier this month are among the first included in the expanded bowel cancer screening program under a $16 million Federal Government initiative, but a two-year delay in its extension to 70-year-olds doesn't make sense for at least one reader.

The age-specific incidence of colorectal cancer increases with age. Does the exclusion from screening of elderly subjects over age 70 represent discrimination on the basis of age? The cost to the community certainly does not decrease for those in their eighth decade.

By Russell Fitch

The Senate has taken the rare step of urging an anti-vaccination group to disband, condemning its "harmful and unscientific" scare campaign that is helping undermine national immunisation rates, to the delight of at least one reader.

I would invite all AVN (Australian Vaccination Network) members to take a short but informative walk through Rookwood cemetery if they doubt the value of vaccination.

by Rod Bernard (not verified)

The Government has announced it will introduce a $2000 a year cap on tax deductions for work-related self-education expenses. The idea has drawn a sharp response from many readers, and some suggestions as to how it could be far better targeted.

I am a joint trainee with the Royal Australasian College of Physicians and the Royal College of Pathologists of Australasia (RCPA). My RCPA annual fees are $1078.

The examination fees for my part one exam are $2170. This year I have bought text books, attended multiple courses and conferences and done one university summer school subject. $2000 doesn't even come close to my educational costs for a year. I am a full-time working single mother with children aged two and five years old. I am already in debt. This $2000 cap will impose a crushing financial burden on me.

by Lucy Ding (not verified)

While I think that the $2000 cap is insufficient to cover a lot of CPD courses required for continuing registration, I think that there are ways to reduce abuse of this education tax deduction. The Government could do this by limiting the amount that could be spent on hotels and flights by establishing a reasonable price for flights and accommodation e.g. 4 star/business hotel and economy class flight to wherever the conference or professional development course is held. If doctors need to travel first class or stay in five star hotels - they can pay for the upgrade. Either nothing will change because no one is abusing this tax deduction, or the people who were abusing it will stop.

by Junior doctor (not verified)

I recently approached several financial institutions to obtain a loan for work-related self-educated expenses while on fellowship. Unfortunately, these institutions can no longer support such loans for professional development expenses. The reason they gave was "recent changes to the National Consumer Credit Protection legislation".

This has potentially catastrophic long-term implications for our health care system.

Fellowships are not a pre-requisite of clinical practice. Most Fellowships, especially those in Canada and the UK, are poorly paid or even unpaid. Not all trainees have the financial freedom to go for 12 to 24 months unpaid or losing money. If trainees cannot guarantee a large personal loan to support themselves and their family while abroad, they will skip this additional training. This is a fact.

The $2000 cap on work-related self-educated expenses is a gross underestimate of the actual cost of training, let alone the "optional" additional self-education expenses that are incurred through Fellowships.

Unfortunately, my wife and I are currently re-assessing our plans to undertake two Fellowships (one in Cambridge, UK; and one in Vancouver, Canada). Our visitations while abroad will also be cut back. This will undoubtedly have a long-term negative effect on our medical community and, ultimately, on our quality of health care. I request that the Government reconsider the $2000 cap to medical work-related self-educated expenses.

by James McLean (not verified)

TO COMMENT CLICK HERE

Research

Bionic vision within sight

A bionic eye that restores sight to people blinded by damaged optical nerves could undergo human trials as soon as next year.

In the latest advance in efforts to restore function to damaged senses in humans, the Monash Vision Group - a partnership between Monash University, Alfred Health, MiniFab and Grey Innovation – have developed a bionic eye that could improve the sight of 85 per cent of the visually impaired.

The device is designed to bypass damaged optic nerves and – using wireless signals transmitted to an implant in the brain – provide a sense of sight,

The bionic eye uses a digital camera - embedded on the left hand side of the head - to capture detailed images which are modified by digital processors and transmitted to a chip implanted at the back of the brain.

The chip, which is implanted on the surface of the brain, presents what is "seen" by the camera as a series of mapping dots representing the outline of nearby objects.

The device is still under development, but researchers believe it will help people suffering a wide range of visual impairment, including all three of the main causes of blindness in Australia – diabetic retinopathy, glaucoma and macular degeneration.

It is suitable for use in patients whose visual cortex is intact, but who have acquired retinal, optic nerve and ocular damage.

Bluesky Group Director and practicing professional at Monash Art Design and Architecture, Mark Armstrong, has come together with engineers, computer scientists and medical researchers from Monash University, Alfred Health and industry partners Grey Innovation and MiniFAB to design the latest prototype.

The team is focused on creating a product that is wearable, comfortable and lightweight, so that it is suitable for everyday use.

In addition to the implants in the head, the device includes a hand held vision processor that will provide power to the system, as well as controls to select visual filters and mapping options.

Using normal neurosurgery procedures, the brain implant is inserted through a small area of the skull, which is temporarily removed.

A steralised chip is then inserted and positioned on the surface of the brain. The excised area of skull is then replaced, providing protection for the patient from infection.

The Group is refining the device and making preparations for a demonstration involving at least one human recipient next year.

Sanja Novakovic

TO COMMENT CLICK HERE

Pregnant mums could hold key to autism

Autism has been linked to the immune system of pregnant women, according to a recent study.

University of California researchers have identified maternal antibodies that are programmed to attack the body's own antigens in the foetus, where they interfere with brain development.

This results in maternal autoantibody-related (MAR) autism, which may account for as much as 23 per cent of all cases of the condition.

The study found that the autoantibody was present in only 1 per cent of mothers whose children did not have autism spectrum disorders.

The researchers believe they have found the targets of these maternal autoantibodies, which may lead to medical interventions that limit a developing baby's exposure to damaging antibodies.

The researchers also found the autoantibodies could change the social behaviour and brain mass of a close primate cousin, the rhesus monkey, in ways that are parallel to autism's symptoms in humans.

Lead researcher and immunologist from the University of California Judy Van de Water said identifying targets for the oddly-programmed proteins has taken years, and that she and her colleagues had struggled to tease out all the identities of the compounds from a range of suspect molecules identified through clinical imaging.

Through a complex series of lock-and-key experiments, the research team identified seven foetal antigens that were attacked by the maternal autoantibodies.

All but one has been linked with the creation and development of neurons, particularly in the hippocampus. This region of the brain, which is associated with memory and learning, has been tied to autism in many previous studies.

Essentially, lock and key experiments are when the correctly sized key (substrate) fits into the key hole (active site) of the lock (enzyme).

Around one in 100, or almost 230,000, Australians have autism spectrum disorder, which is characterised by problems with social and communication skills, restricted and repetitive interests and behaviours, and unusual ways of learning and paying attention.

The research was published in *Translational Psychiatry.*

Kirsty Waterford

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

A career in radiation oncology

Medical students are being urged to consider a career in radiation oncology amid concerns that thousands of patients could miss out on timely access to potentially life saving treatment because of a shortage of trained practitioners.

The Royal Australian and New Zealand College of Radiologists has launched a campaign to promote careers in radiation oncology as part of a national plan to eliminate current shortfalls and inefficiencies in the provision of radiation oncology services, with estimates that at least 18,000 cancer patients missed out on receiving potentially beneficial radiotherapy last year.

The campaign, funded by the Department of Health and Ageing, aims to avert predicted workforce shortages by promoting the three specialties in radiation oncology: radiation oncologists, radiation therapists and radiation oncology medical physicists.

The College said that although not all three radiation oncology professions were currently in short supply, there was a need to promote them to improve the calibre of students attracted to the specialty.

The campaign is primarily directed at high school students, but radiation oncology will also be promoted as a career option for university students.

The campaign, which is being conducted in collaboration with the Australian Institute of Radiography and the Australasian College of Physical Scientists and Engineers in Medicine, is intended to help achieve an optimal radiotherapy target utilisation rate of 52.3 per cent of new cancer patients by 2022.

For further information, contact RANZCR Project Officer Mel Grand via email mel.grand@ranzcr.edu.au or phone +61 2 9268 9765.

For more information on the radiation oncology workforce, please visit www.radiationoncology.com.au

For further information on a career in radiation oncology, please visit www.acareerinradiationoncology.com.au

TO COMMENT CLICK HERE

Poor priced out of market for life-saving drugs

Millions of HIV sufferers are being denied life saving treatments because patents are stifling competition and pushing costs well out of the reach of the world's poor, according to international medical humanitarian organisation Medecins Sans Frontieres.

In a report released at an International AIDS Society conference in Kuala Lumpur early this month, MSF found that the price of first and second-line HIV drugs had plunged because of intense competition between rival generic medicine manufacturers, putting them increasingly in reach of the estimated 34 million people worldwide living with the disease – 70 per cent of whom are in sub-Saharan Africa.

According to the MSF, in the past year alone the annual cost of treatment with the first-line pill recommended by the World Health Organisation – a combination of tenofovir, lamivudine and efavirenz – has fallen by an average of 19 per cent to $139 per person, with several countries able to secure even larger discounts through bulk purchases.

The emergence of new generic pharmaceutical manufacturers has also helped drive even sharper falls of close to 30 per cent in the price of the two key second-line treatments – with the cost of one plummeting by 75 per cent since 2006.

But, despite these declines, the cheapest second-line treatment is still more than double the price of first-line treatments, and MSF has warned that newer antiretroviral therapies still under patent remain at astronomically high and unaffordable prices.

MSF Medical Director Dr Jennifer Cohn said it was "good news that the price of key HIV drugs continue to fall as more generic companies compete for the market, but the newer medicines are still priced far too high".

The latest HIV drugs are needed to treat patients whose infection has not responded to the first and second-line therapies.

But the desperately needed new HIV medicines, including critical new classes of antiretrovirals, are extremely expensive because patents protect them exposure to competition, according to MSF.

The best combination of medicine for people who have failed first and second-line treatments costs more than $2000 a year per person in the world's poorest countries.

In some nations, including Jamaica and Thailand, just one of the four components making up such drugs cost up to $6570 a year for each patient.

In addition to these concerns, health workers are worried that reliance on new generation HIV therapies will intensify as increasing use is made of a broader range of drugs in the first and second lines of defence against the infection.

HIV experts claim that well-tolerated drugs, such as the integrase inhibitor dolutegravir, may be used in the future in first and second-line treatments, making affordable access to newer drugs even greater priority.

According to MSF, treating the millions infected with HIV will increasingly depend on the bringing down the price of newer drugs.

HIV pharmacist at MSF, Arax Bozadjian, said that "today there are no quality-assured generic options for a large majority of the newer HIV drugs," Ms Bozadjian said, warning that this was not simply a problem for the world's poorest nations.

"Prices in middle-income countries are also of major concern," she said, adding that many had little access to much-needed regimens because they were excluded from existing voluntary agreements.

Much of the fall in the cost of first and second-line combination HIV drugs has been attributed to the proliferation of generic drug manufacturers in India.

But industry observers are concerned that, with newer HIV medicines being patented at an increasing rate, it will be vital to find a solution to tackle the high-price problem.

In a study presented to the conference, Australian researchers provided evidence that

A reduced daily dose of one antiretroviral drug is just as effective – and much cheaper – than the current recommended treatment regime.

Professor Sean Emery from the University of New South Wales' Kirby Institute said health authorities and patients could save up to $20 per person each year from the cost of HIV medication by using reduced doses of the drug efavirenz, which is currently used as part of combination antiretroviral therapies that cost up to $75 a year per patient.

"We've been able to show, with some very robust data, that it is possible to administer a reduced daily dose of [efavirenz] to people with HIV…in a way that doesn't affect the ability of that drug to save their life, and it's also associated with some reduced side effects," Professor Emery told ABC radio.

...CONTINUED ON PAGE 34

Health authorities on alert as MERS death toll grows

Health authorities from around the world are monitoring an outbreak of the Middle East respiratory syndrome coronavirus (MERS) that has so far claimed more than 40 lives and left dozens more seriously ill.

As at late last week, 80 laboratory-confirmed cases of the SARS-like illness had been identified in eight countries, though Saudi Arabia is at the epicentre of the outbreak, accounting for 80 per cent of all diagnoses.

No cases of the illness - which has so far killed 44 people worldwide - have yet been reported in Australia, but health authorities internationally are on alert for the possible widespread transmission of the disease when hundreds of thousands of pilgrims and visitors descending on Saudi Arabia and other Gulf countries during the holy month of Ramadan begin to return home late this month or in early August.

There are even greater fears that the annual Hajj pilgrimage – which draws millions of travellers from around the world to Saudi Arabia in October – could see the disease appear in dozens of countries.

The World Health Organisation has reported clusters of outbreaks of MERS, confirming that it can be transmitted person-to-person, though there are doubts about just how easily communicable the disease is.

Most of those who have so far contracted the disease, which is a serious respiratory tract infection characterised by symptoms including fever, cough and breathing difficulty, have been middle aged with underlying conditions.

This has made it more difficult to identify symptoms of the illness. For example, many who have contracted it have suffered renal insufficiency or failure, but clinicians are unsure whether this was caused by the disease or was part of underlying conditions that made patients vulnerable to the infection in the first place.

So far, 38 people in Saudi Arabia have died after contracting MERS, but officials are still yet to identify the source of the infection.

Health experts believe the disease may have jumped species, and investigations are centring on a bat colony discovered in an abandoned village in the country's remote southwest, according to the *New York Times*.

But, in an update released late last month, the Department of Health and Ageing (DoHA) warned that bats may not be the immediate source of infection.

"It is unlikely that many of the patients had contact with bats, and the possibility that a single spill-over event occurred to an intermediate animal host species, subsequently leading to human infections, is more likely," DoHA said.

It said phylogenetic data indicated the first human was infected in 2011, though the first confirmed death from the disease was not until June last year.

Although there have as yet been no confirmed cases in Australia, Chief Medical Officer Professor Chris Baggoley has held a teleconference with peak medical bodies to inform them of the infection, and Commonwealth, State and Territory health authorities are working together to monitor the situation.

The Department said test kits suitable for diagnosing MERS are available, if required, and further information on the disease for patients, GP, labs and public health workers at www.health.gov.au/MERS-coronavirus.

The Communicable Diseases Network of Australia has recommended that tests for MERS should be conducted on patients with pneumonia who have recently lived in, or travelled to, the Arabian Peninsula, as well as those who have been in close contact with them.

But at this stage travellers are not being advised to cancel plans to visit the area.

Adrian Rollins

TO COMMENT CLICK HERE

Poor priced out of market for life-saving drugs

...CONTINUED FROM PAGE 33

In a separate report to the Conference, MSF examined the cost of viral load tests, which are considered the "gold standard" for monitoring HIV treatment in developing countries. The WHO has recommended their widespread use, but price and complexity have so far slowed the roll out of these and other diagnostic technologies.

"Viral load testing is the best way to keep people on the most affective and affordable treatment for as long as possible," Dr Cohn said. "With the price of second-line treatments coming down, it's really time to start testing people's viral load, and making sure people are on a treatment that works for them, instead of waiting until its too late and they get sick again or even die."

Jeremy Mole

TO COMMENT CLICK HERE

Le Tour de High Country

BY **ADRIAN ROLLINS***

Bright Boot Camp cyclists enjoy a rare flat stretch in the High Country

Pity the French.

Every year they host one of the biggest sporting events in the world, the Tour de France, and every year they come away empty handed.

The three-week cycling marathon showcases the French countryside but not, it seems, it athletic prowess.

Glance through the list of winners in recent years – from the skinny beanpole Brit Bradley Wiggins and jockey-like Cadel Evans through Spaniard Alberto Contador and the rider-from-Texas-whose-name-no-one-dare-mention – and there is not a monsieur among them.

You have to go back to 1985 to see the last time a Frenchman stood on the top step of the podium in Paris to shouts of allez.

And, with less than two weeks of the races 100th edition to go, it appears the dominance of the dastardly English-speakers is set to continue.

African-born Chris Froome from the British team Sky Racing is in the yellow jersey of race leader and, ably supported by his Tasmanian lieutenant Richie Porte, looks set to hold onto it right through to the finish – barring accidents and illness.

Earlier, Australia got its taste of yellow when Simon Gerrans, from the Australian-registered team Orica-GreenEdge, spent two days as race leader, before handing on the privilege to his South African teammate Darryl Impey.

Of course, it only falls to a tiny fraction of those who throw a leg over a bike to ever participate in the Tour de France, let alone lead it or win it.

But one of the beauties of cycling is that enthusiastic amateurs can get a taste of what it is like to be a professional – riding the same bikes as the pros (one of the quaint rules of the sport is that professional teams are only allowed to ride bikes that are available to the general public), and on the same roads.

...CONTINUED ON PAGE 36

Le Tour de High Country

...CONTINUED FROM PAGE 35

Cyclists pass Rocky Valley Lake at Falls Creek

And, occasionally, there is the chance to emulate the lifestyle of the pro, if only for a few days.

This was the case earlier this year when a group of about 30 keen cyclists (this writer included) descended on the Victorian alpine resort town of Bright for a four-day training camp.

For those bitten hard by the cycling bug, the Bright Boot Camp – run by David Heatly and Jodie Batchelor from Cyclinginform every February and November since 2007 - is about as good as it gets.

For four days, all we had to think about and do was ride our bikes in the morning, then eat and rest in the afternoon, go to the local pub for dinner (which included expert advice on cycling training, nutrition and equipment) before crashing out and doing it all again.

Which was just as well, because the cycling was physically challenging.

From Bright – which is just down the road from where Simon Gerrans grew up and started cycling - just about every road goes up, and in four days the group rode 420 kilometres and ascended 6300 metres.

While this is nothing compared with the distances covered by the pros, it was a testing regime for we amateurs.

The first ride of the camp was a 60 kilometre round trip to the top of Mount Buffalo and back.

The climb up Mount Buffalo is 18 kilometres long, with an average gradient of 5.6 per cent, and was used as a way to seed riders into one of three groups, which they would ride with for the rest of the camp.

Day Two was the biggest challenge – a climb over Tawonga Gap (six kilometres, 6.6 per cent gradient) before a 30-kilometre drag up Falls Creek (average gradient 4 per cent) and return.

The Falls Creek climb compares with any of the major Alpine or Pyrenean ascents tackled by the Tour, minus the crowds, the altitude, the quaint villages or the lung-busting surges.

The first half of the climb is deceptively gentle, rising just 400 vertical metres and lulling the rider into a false sense of confidence. It begins to bite at the 16-kilometre mark, where the road pitches up, and the gradient rarely drops below 6 per cent for the remaining 13 kilometres. Throw in a bit of a head wind, and it can be a grind.

But the reward for all the effort is a glorious, virtually traffic-free 30-kilometre descent.

The third day of the camp traditionally involves a gruelling climb up Mount Hotham, but a still-smouldering bushfire meant the road was closed and we instead did a 120-kilometre loop out to Beechworth.

The camp finished on Day Four with a 110-kilometre ride over both the Rose and Tawonga gaps.

True, Australia's alpine country is nothing like the soaring slopes of the Alps.

But for those who hanker for a taste of the professional cyclist lifestyle and want to hone their fitness, but can't afford the time or expense of a trip to the French Alps or the Pyrenees, a four day sufferfest in the Victorian high country is a very good – and far cheaper – alternative.

What	Bright Boot Camp (http://www.cycling-inform.com/bright-boot-camp-home)
Where	Bright, Victoria
How to get there	By car, four hours drive from Melbourne; seven hours drive from Sydney
Cost	$949 (incl accommodation); $574 (accommodation not included)
When	1-5 November 2013; 21-25 February 2014

** Adrian Rollins is Editor, Australian Medicine*

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Seppelt Wines- a Cougar under wraps

BY **DR MICHAEL RYAN**

Sexy wine labels that attract the young groovy wine buyer abound. Evocative cartoon labels with Barbarella-style cleavages on display attract many sets of eyes.

But take a step back and see the well-controlled, stylish labels that just ooze culture, intrigue and a certain element of the dominatrix.

I have found my new mistress under the label of Seppelts, entrenched in the township of Great Western in Central Western Victoria.

Being steeped in history counts for a lot. In 1851, Joseph Seppelt started a vineyard in the Barossa. The Grampians vineyard was started by Jean Pierre Truette and Anne Marie and Emile Blampied in 1863. There were several changes of ownership of the Victorian site – which went through the hands of James Best and Hans Irvine – before coming under the Seppelt umbrella when Beno Seppelt assumed stewardship in 1918.

Hans Irvine deserves congratulations for refining the methode traditionale for sparkling wines used by French champagne maker Charles Pierlot. The result was the world's first sparkling Shiraz.

Why not take a curvy specimen like a seductive refined cool climate Shiraz, and morph it into a buxom, slinky-clad temptress draped in a veil of satin?

But under Seppelts the vineyard lost any inertia it had developed and surged n popularity.

It is now owned by global operator Treasury Wine Estates, which has appointed Adam Carnaby as head wine maker. He has contagious energy to burn, having done vintages at Yering Station in the Yarra Valley and Xanadu in the Margaret River. He had an epiphanous year in Burgundy that opened his eyes to the simplicity and sensual nature of wine.

This sensuality started to emerge in his 2012 releases.

Like most great wine makers, he believes it all starts in the vineyard. His "Marilyn Monroe with a number 15 riding crop" is the fruit that comes from the great vineyards of Henty, Heathcote and of the iconic Great Western. More specifically, the 1863 St Peters Vineyard at Great Western.

Adam has a bachelor of applied science from the Royal Melbourne Institute of Technology, and completed his wine science degree at Charles Sturt University.

These are merely tickets of entry into the big game, as this boy knows how to conduct himself and coax the most from the mistress that is created in the vineyard.

"I want the brand to be grand again with its sense of desirability," Adam told Australian Medicine.

I think Mr Seppelt would be proud.

WINES TASTED

1. 2011 Seppelts Grampians Great Western Riesling

one of the great areas to make Riesling, apart from the Clare and Eden valleys. It is a very pale yellow to the eye, with a bright lime and floral nose. The warm, wet summer is evident as secondary sweeter notes develop. The palate is strongly anterior, but a combined synergy of high natural acid and residual sugar (9.5 grams per litre) enable the wine to linger and satisfy the back palate. It has sherbet-like characteristics. Have with sashimi snapper, and be prepared to watch the development in the cellar over seven to nine years.

2. NV Seppelts Salinger

This methode traditionale sparkling is the baby sister of the well-known Vintage Salinger. It is one of the few Australian blends of Pinot Noir, Chardonnay and Pinot Menueir. The colour is a maturing yet vibrant deeper yellow. The nose is indicative of its pedigree and quality. Cut lemons combine with alluring yeasty notes. The mouth feel is soft and supple, with a pleasant spread of fine bubbles and lengthy acid structure. Oysters, and more oysters, would never disappoint.

2008 Seppelts Drumborg Chardonnay – the cool climate of Henty produces elegant fruit for many Seppelt wines. The 1964 single vineyard plantings give up their treasure, and Seppelts gratefully mould them into great wines. The Chardonnay is medium yellow/straw colour. Classic white peach, some floral notes and nutty fragrances abound. The wine then develops its more preserved meat and yeasty notes as it warms up. The palate is full and satisfying. The wonderful fruit presence is bolstered by mouth feel and acid structure. Goat's cheese soufflé would match. Cellar for five to seven years, and see how it evolves.

3. 2008 Seppelts Drumborg Pinot Noir

Cool climate effect, with an average of 17.5 degrees Celsius in January. The pale garnet colour is a somkescreen for the power to come. The nose has a wonderful red fruit spectrum, with hints of white pepper and twiggy floral. Juicy fruit notes swill around the mouth, and seamless tannins provide great structure. This is a cracker. Enjoy with duck terrine with mushrooms and tarragon. This will cellar well, but who can wait?

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