Canberra DOCTOR
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In the third of a series on Canberra's hospitals, this month we feature Canberra Hospital

The Canberra Hospital Emergency Department (ED) expansion is underway, with work officially beginning on the project in April. The expansion will enable Canberra Hospital to address the increasing presentation numbers to its ED.

The ED at Canberra Hospital is the ACT region's major trauma centre. Over the 2013-14 financial year alone it treated more than 70,000 patients, which is the highest number ever recorded for a single year in this ED. Presentation numbers are continuing to increase.

The expansion construction plan allows for continuous operation of the ED while new areas are opened progressively throughout the project. Construction will be underway 24 hours, 7 days a week to ensure the project can be delivered as early as possible. It is anticipated that the expansion will become operational in late 2016.

The expansion will provide a total of 21 more beds and improve the layout of the ED, creating efficiencies that will lead to an expected reduction in waiting times. It will deliver up to nine more acute beds for patients with severe conditions, three more beds or cubicles for patients with less severe problems and three more beds in the Emergency Management Unit, which provides care for short-term patients. There will also be two more paediatric beds, two more resuscitation bays, a new Mental Health Assessment Unit with two more beds and three additional ambulance bays. When these works are complete, they will create an extra one thousand square metres of floor area in the ED.

The expansion will include the integration of a $5 million Paediatric Streaming function, which has been funded by the Commonwealth Government. This will involve transferring children and their parents or carers to a dedicated waiting area for young people prior to treatment.

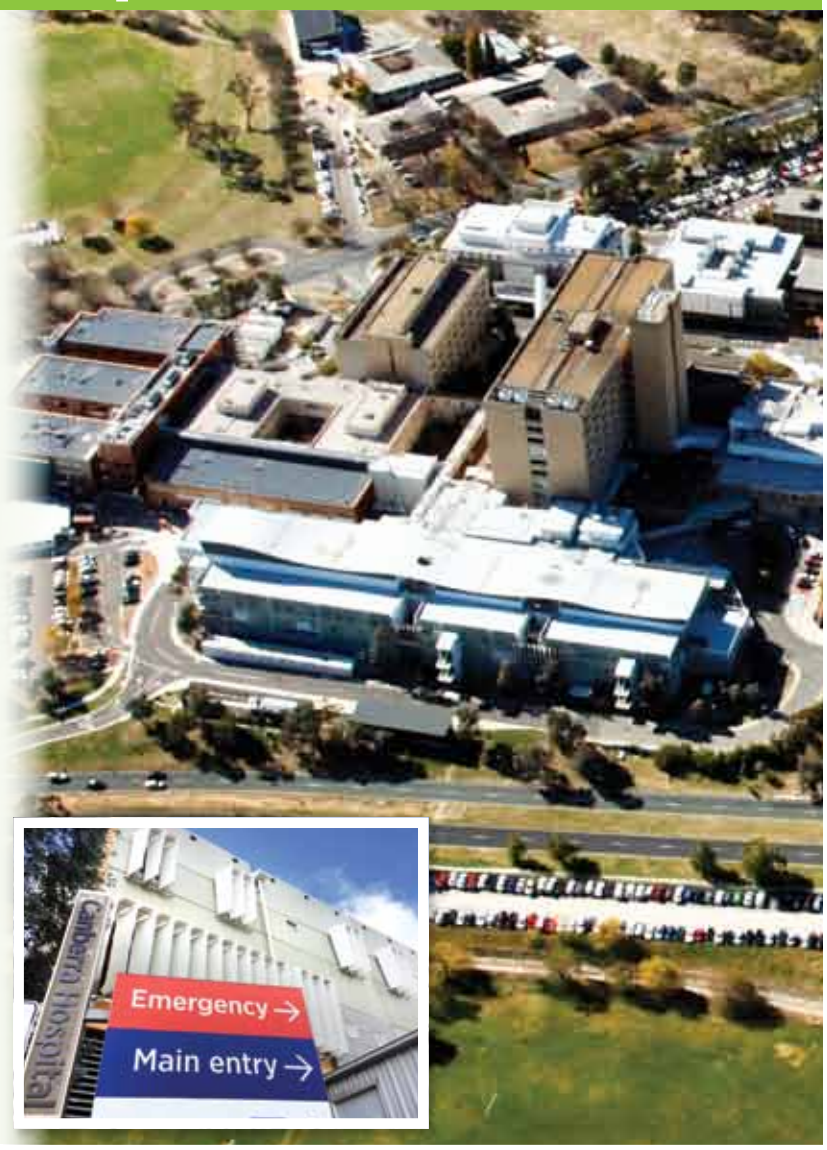
The $23 million ED expansion is part of the ACT Government's Health Infrastructure Program, which is investing in Canberra's health by changing how and where patients are cared for.

Paul Carmody, Deputy- Director-General of Health Infrastructure and Planning at ACT Health said that since 2009, almost $880 million has been invested in the Health Infrastructure Program.

"This investment has already seen upgrades to existing facilities, and new facilities including the Canberra Region Cancer Centre and the Centenary Hospital for Women and Children. There are several other projects on the horizon as well, including the University of Canberra Public Hospital in Bruce and the Secure Mental Health Unit in Symonston."

The Health Infrastructure Program is one of the biggest infrastructure investments in the ACT's history. New and upgraded facilities are opening across a wide range of areas in the ACT health system, which will help to support the health and wellbeing of the community in a variety of ways.

For anyone who would like more information on the various projects underway as part of the Health Infrastructure Program, more information is available at www.health.act.gov.au.



Capital Conversations with President, Dr Elizabeth Gallagher

By the time you receive this edition of Canberra Doctor, I will have completed my first 12 months as President of the AMA.

Some of which follows has been provided to AMA members through the Annual Report, but I thought it would be of interest to those colleagues who are not members, to hear what we have been doing during the last twelve months. In the interests of brevity, not everything is reported on, but hopefully it will assure all that your AMA is working hard for you, the profession and our patients.

Firstly, I thanked my Board, and Christine Brill for their support and guidance throughout my first year in office. My thanks too to those members who contribute through our Advisory Council, GP Forum and Doctors in Training Forum. I have learned so much about medical politics, our profession, medical care, public speaking, and media.

The year started with a bang – with me taking the reins only 24 hours after the Abbott government brought down what must be one of the most controversial health budgets in history. In retrospect, most of the changes now have either been modified or abandoned, and none have got through the Senate. Thanks and congratulations need to go to A/Prof Brian Owler and my federal AMA colleagues who have spent the majority of their first year dealing with these issues up on Capital Hill. They have had a huge impact on how this all shaped up.

AMA (ACT) has continued to maintain its relationships with the ANU medical School and our new interns. At the beginning of the year we held our own meet and greet with the Year 1 medical students at the University Pub. At the end of the year we held a breakfast for the graduating class, and we sponsor the AMA award for leadership which is awarded to a final year student nominated by peers and/or academic staff who has shown outstanding leadership, and I congratulated Dr Kerrie Aust who was last year's winner and who is now an Intern in Canberra. Students are represented on our doctors in training forum, advisory council and the "Canberra Doctor" editorial committee. We are working with the student leaders to bring some new initiatives to fruition which will both enhance our engagement with the future of the profession and provide them with some valuable strategies for life after graduation.

We hosted lunch for the new interns during their orientation week and we unashamedly promoted why membership of the AMA is important to them personally and professionally. It is pleasing that the majority of our new doctors join the AMA. This engagement enhances our ability to effectively advocate for them on workplace and other profession-centred and personal issues. Our doctors in training forum continues to engage with Canberra and Calvary hospital JMOs. Agenda items of concern over the year have been the enterprise agreement negotiations and of course the increased numbers of medical graduates and the pressure for training places as a result. The health and well-being of our junior medical workforce has also been a top of mind issue and discussed at the AMAs Council of Doctors in Training (AMA CDT). My thanks to Drs Chloe Abbott and Zafreen Rahman for volunteering to represent their peers at the AMACDT in 2014. They have been succeeded this year by Dr Nushin Ahmed and Catherine Greenshields, who will be great contributors as their predecessors have been.

Our thanks too, to Dr James Fergusson who "retired" from the role of ACT representative on the AMA Council of Salaried Doctors and to Dr Toby Angstmann who has taken over this role.

General practitioners have been well represented by Dr Suzanne Davey, who as well as being the ACT representative to the AMA Council of General Practice (AMACGP), chairs our GP Forum and is a member of the Board. Suzanne's reports on GP issues through Canberra Doctor are valued and valuable.

I also hosted our inaugural Time Lords and Ladies lunch at AMA house. Invitations were extended to former Presidents and Fellows and members who have maintained their membership for 50 years or so. I was privileged to hear stories about the Canberra medical community and the AMA in Canberra dating back many, many years. We hope to make this a new annual tradition. Dr Peter Brown (President 1976-77) has been collecting profiles of our local doctors and these are now in the custody of the AMA and our CEO. Christine Brill has undertaken to collect more of these rich stories to add to the collection with a view to maintaining an archive of our profession's contribution to medicine in Canberra and the region.

Local issues the AMA has been involved in include contract negotiations for the salaried doctors, to say this has been controversial is an understatement. Firstly, with negotiations being held separately to ASMOF, and now the lack of agreement on the final contract – owing to a technical breach and subsequent referral to Fair Work Australia. The bargaining period for the next round of VMO contract negotiations begin in August, with dates for arbitration looking to be in early February.

More political issues include the ACT Cannabis legislation put forward by Greens member and Corrections Minister, Shane Rattenbury. I recently appeared to give evidence at the committee hearing. I expect it to be a few more weeks before we know what the recommendations are.

The NSP is a work in progress (or not). The CPSU has just reached an agreement with the Director of Justice and Community Safety department to remove any link to the NSP from their contract. Hopefully this will allow freer dialogue between the CPSU, ACT Government and other interested parties such as ourselves and Winnunga Nimmityjah Aboriginal Health Service.

"Canberra Doctor" goes from strength to strength. It is only a few years ago that it was a cost to the Association, but in recent years it has become a real contributor to the finances of AMA (ACT). My thanks go to the editorial committee for their wise counsel in determining what we print and to our production team led by our CEO for bringing it to you. Of course, our thanks to our contributors and to our advertisers – they make it possible. My thanks too, to Dr Ian Pryor who has chaired the editorial committee for several years and I welcomed Dr James Cookman who has taken on the role.

I would like to acknowledge the strong and respectful relationship we had with our former Chief Minister and Health Minister (and now Senator) Katy Gallagher and I welcome a continuation of this with new Minister, Simon Corbell. I'd also like to acknowledge the relationship we have with the Opposition Leader and Shadow Health Minister, Jeremy Hanson. We have enjoyed robust discussions and have agreed to disagree on occasions. Nevertheless, we welcome the engagement.

I make the same remarks in relation to the leadership team of the Health Directorate. Dr Peggy Brown has been available and accessible to talk with me when issues have arisen and we have regular meetings with Peggy and her team: Ian Thompson and Stephen Goggs. We wish Peggy well as she leaves the role of Director General and we look forward to welcoming her successor in due course.

To conclude, thank you, each and every member for your commitment to the AMA. It is the only organisation for the whole profession and its dedication to your personal and professional wellbeing through advocacy on issues such as the freeze on Medicare rebates, the cap on education expenses, the GP co-payment issue etc etc cannot be underestimated.

I'd be happy to speak to any medical practitioner about the benefits of membership; we need to be a strong and united profession if we are to achieve outcomes of value to the profession and to our patients.

Médecins Sans Frontières launches global campaign to reduce the price of pneumococcal vaccine to $5 in developing countries

Médecins Sans Frontières (Doctors Without Borders) has launched a global campaign to call on pharmaceutical companies GlaxoSmithKline (GSK) and Pfizer to slash the price of the pneumococcal vaccine in developing countries to US$5 per child.

"As doctors who have seen too many children die of pneumonia, struggling to breathe, we are asking anyone who cares about children's lives to join our public call on Pfizer and GSK to make sure all developing countries can afford to protect all their babies against this killer disease," said Dr. Greg Elder, Director of Operations for Médecins Sans Frontières in Paris.

"The sky-high prices Pfizer and GSK charge for the pneumococcal vaccine prevent many governments and humanitarian organisations from vaccinating children, and after seeing the price to vaccinate a child rise substantially over the past decade, we have no choice but to take action now."

One child every 22 seconds will die of a vaccine preventable disease. That's 1.5 million children each year. Pneumonia is one of the biggest child killers but the pneumococcal vaccine can help protect against it.

A 2015 Médecins Sans Frontières report shows that in the poorest countries, the price to vaccinate a child is now 68 times more expensive than in 2001. Many parts of the world are unable to afford new high-priced vaccines like that against pneumococcal disease, which kills about one million children each year.

Part of the reason vaccination has become so costly is linked to the fact that very little information on vaccine pricing is available, leaving many developing countries and humanitarian agencies to negotiate with pharmaceutical companies from a very weak position, with no way to compare prices. Some countries have to sign confidentiality clauses that prevent them from disclosing the price they pay for their vaccines.

Médecins Sans Frontières staff attending the shareholder meeting will ask questions from the floor, pushing the company's board members to disclose the price of their pneumonia vaccine in all countries.

In around 45 countries, there is no information about the price for the pneumococcal vaccine; this secrecy and lack of transparency in how companies set prices prevents governments from having a fair shot at protecting their children with an affordable vaccine. It's led to the irrational situation where some middle-income countries pay more for the pneumococcal vaccine than wealthy ones. For example the Philippines pays more than Australia.

"The level of pharma's secrecy is astonishing— we can't get information from Pfizer and GSK on what they charge countries for the pneumococcal vaccine. The question we are asking is, how any country can negotiate fair vaccine prices when critical information is missing?" said Dr. Manica Balasegaram, Executive Director of Médecins Sans Frontières' Access Campaign.

"It's absurd to see the pricing information of a life-saving product kept secret, with countries and organisations left in the dark when trying to negotiate a fair price."

Each year, Médecins Sans Frontières teams vaccinate millions of people, largely in response to disease outbreaks such as measles, meningitis, yellow fever and cholera. Médecins Sans Frontières also supports routine immunisation activities in projects where it provides health care to mothers and children. In 2013 alone, Médecins Sans Frontières delivered more than 6.7 million doses of vaccines and immunological products.

Médecins Sans Frontières has purchased the pneumococcal conjugate vaccine (PCV) in the past for use in its emergency operations. In 2013, Médecins Sans Frontières vaccinated with PCV and pentavalent vaccine in Yida refugee camp, South Sudan. In 2014, similar vaccination activities with the PCV vaccine were conducted for refugees in Uganda and Ethiopia. Médecins Sans Frontières is scaling up its use of the PCV vaccine and other vaccines with a particular focus on improving its work in routine immunisation, as well as extending the package of vaccines used in humanitarian emergencies.

New report highlights the risks to human health from climate change

AMA President, A/Prof Brian Owler, said that the latest comprehensive scientific evidence on the serious risks that climate change poses to human health should be a catalyst for the Federal Government to show leadership in reducing greenhouse gas emissions ahead of the United Nations Climate Change Conference in Paris later this year.

A/Prof Owler said that the Australian Academy of Science Report – *Climate change challenges to health: Risks and opportunities* – is a call to action for all Australian governments to prepare for the major impacts of climate change, which include extreme weather events, the spread of diseases, disrupted supplies of food and water, and threats to livelihoods and security.

A/Prof Owler co-launched the Report with President of the Australian Academy of Science, Professor Andrew Holmes, at Parliament House in Canberra recently.

"The Report brings together high level research across science, social science, and technology to provide a comprehensive overview that fills the knowledge gap on the impacts of climate change on human health.

"The health effects of climate change include increased heat-related illness and deaths, increased food and water borne diseases, and changing patterns of diseases.

"In addition to their impact on health infrastructure and services, extreme events such as droughts, flooding, and storms could be responsible for death and disease.

"The Report's recommendations will assist all our governments prepare for the inevitable health and social effects of climate change and extreme weather events, and must be a key reference for the Federal Government in the development of the action plan it takes to the Paris Climate Change Conference.

"The Paris Conference objective is to achieve a legally binding and universal agreement on climate from all nations of the world, and the AMA believes Australia should be showing leadership in addressing climate change and the effects it is having, and will have, on human health."

A/Prof Owler said it is the AMA's view that climate change is a significant worldwide threat to human health that requires urgent action.

"We recognise that human activity has contributed to climate change," A/Prof Owler said.

"Climate change will dramatically alter the patterns and rate of spread of diseases, rainfall distribution, availability of drinking water, and drought.

"In Australia, we are already experiencing weather extremes with prolonged drought and bushfires in some areas and severe storms and floods in others.

"There are predictions of longer term effects such as rises in sea levels, increases in sea surface temperature, coastal erosion and contamination of estuaries.

"International research shows that the incidence of conditions such as malaria, diarrhoea, and cardio-respiratory problems is likely to rise.

"All these events will affect the health of Australians and the health of the people in other countries in our region.

"The Academy recommends that Australia establish a National Centre of Disease Control to provide a national and coordinated approach to Australia's response to climate change.

"Such a Centre would prioritise research and data collection to better evaluate and anticipate where the burden of disease from climate change would have the greatest effect, and be able to respond accordingly.

"Doctors and other health workers need to be informed by sound up-to-date data. For example, we need to know when a disease that is traditionally found in tropical regions has moved south.

"This will allow health authorities to plan and allocate health personnel and services to deal with changing patterns of disease.

"Changing weather patterns and the devastating effects of extreme weather events usually affect the vulnerable, including the elderly and people with limited mobility, the hardest.

"The Academy of Science Report provides the evidence and the recommendations for action and planning.

"Doctors and other health professionals can play an active and leading role in educating the public about the health issues associated with climate change," A/Prof Owler said.

The Australian Academy of Science Report – *Climate change challenges to health: Risks and opportunities* is here https://www.science.org.au/sites/default/files/user-content/documents/think-tank-recommendations.pdf

The AMA released a Position Statement on Climate Change and Health in 2004, which was updated in 2008, and can be found at https://ama.com.au/position-statement/climate-change-and-human-health-2004-revised-2008

The AMA is currently updating this Position Statement.

Good news for Canberrans affected by hepatitis C

Hepatitis ACT has welcomed Pharmaceutical Benefits Advisory Committee (PBAC) recommendations to Government to subsidise new antiviral medicines for the treatment of chronic hepatitis C.

Executive Officer of Hepatitis ACT, John Didlick said "Access to these new drugs under the Pharmaceutical Benefits Scheme (PBS) is incredibly important and time critical, including for an estimated 4,000 Canberrans living with hepatitis C."

If the recommendations are accepted, the Federal Government could change the course of an epidemic directly affecting nearly a quarter of a million Australians. Hepatitis ACT is aware of many people in Canberra who are anxiously waiting on access to new and improved therapies.

More than 230,000 Australians are currently living with hepatitis C, yet only one per cent of them receive treatment each year. More than 600 Australian lives are lost each year to hepatitis C-related liver disease. In the ACT the increasing number of new diagnoses far outweighs the number of people who are treated.

"Many other countries already subsidise the cost of new generation hepatitis C medicines and it is encouraging to see that we might now catch up," John Didlick said.

Mr Dudlick said, "we must ensure that this recommendation is actioned and that bureaucratic red tape does not stand between people with hepatitis C and access to these important therapies."

New generation hepatitis C medicines provide higher cure-rates, shorter durations of treatment and are significantly better tolerated than traditional therapies. They can also support better access to treatment through alternative models of care, taking pressure off tertiary clinics.

OPINION: Medical Negligence: Law, Ethics and Human Rights

By Lisa Hsu

The most common medical negligence resulting in claims was delay in, or failure to diagnose, according to a systematic review article on the epidemiology of medical negligence claims in primary care. This study included claims in USA, UK and Australia and was published in the British Medical Journal (BMJ).

The commonly missed or delayed diagnoses included cancer and myocardial infarction in adults and meningitis in children. The second commonest claim was regarding medication error. Medical practitioners are concerned with the topic of medical negligence, probably from their first days as medical students. Doctors are increasingly required to explain and justify their clinical decisions to patients, colleagues, the media, regulators, and the courts. A solid understanding of the law, ethics and human rights is pivotal to this process and is also essential in meeting the expanding patient expectations.

Medical negligence – Law

Oxford dictionary defines the law as *the system of rules which a particular country or community recognises as regulating the actions of its members and which it may enforce by the imposition of penalties*. The Tort law of negligence is most commonly used to seek compensation for medical negligence. All four elements of negligence need to be shown to establish that the medical practitioner was negligent. Firstly, the medical practitioner owes a duty of care to their patients. Secondly, a breach of this duty had occurred. Thirdly, there was loss or damage suffered by the patient. Lastly, the loss or damage was caused by the breach and were reasonably foreseeable. According to Section 18 of the *Health Professionals Act 2004: The required standard of practice, for a health professional, is the exercise of professional judgment, knowledge, skill and conduct at a level that maintains public protection and safety.* The *Civil Liability Act* (NSW, QLD, TAS) should also be considered when determining whether the doctor's practice fell below the professional standard of care. *A person practicing a profession is not negligent if it is established that he/she acted in a manner at the time that was widely accepted by peer professional opinion as competent professional practice.* This is consistent with the case law: *Bolam v Friern Hospital Management Committee.* This case has been referred to commonly as the Bolam test, in which a doctor is not negligent if the standard of medical care provided is accepted by responsible (or reasonable) body of medical opinion.

Medical negligence – Ethics

The Australian Medical Council developed a national code of professional conduct for medical practitioners – *Good Medical Practice: A code of Conduct for Doctors in Australia*. Doctors have a professional responsibility to adhere to this code and *if serious or repeated failure to meet these standards may have consequences for one's medical registration*. The code is consistent with Beauchamp and Childress' four principles of biomedical ethics, including autonomy, beneficence, non-maleficence and justice. Autonomy refers to respecting patient's decision regarding medical care, even if this decision is against the medical practitioner's beliefs and values. If the doctor fails to disclose a serious complication associated with a surgical intervention, then the patient does not have all the information they need in order to make a decision. This is thereby indirectly violating the patient's autonomy. Beneficence holds that doctors must *do good* for their patients. Non-maleficence comes from the Hippocratic oath as *do no harm*. Medical negligence leading to damage or loss to the patient, physically or mentally, indicates failure in following this ethical principle. Justice encompasses two main categories, fairness and distributive justice. Providing incompetent or inappropriate medical care is unfair to the patient, and potentially also unfair to the healthcare system as this would not effectively utilise resources, hence breaching distributive justice. For example, delayed diagnosis of breast cancer can significantly change the prognosis and management of the condition, as well as using healthcare resources which can be more beneficial to other patients. An early diagnosis of ductal carcinoma in situ (DCIS) requires local excision surgery with very good patient outcomes, compared to very poor prognosis associated with metastatic breast cancer, involving palliative treatment with cytotoxic chemotherapy and extensive hospital stay. However, it is important to accept that doctors are humans after all. It would be too naïve to believe all doctors make the absolutely correct decisions in every aspect of their clinical practices. Therefore it is equally important to understand medical negligence and the course of action when adverse events occur. The AMC Good Medical Practice states that medical practitioners have a responsibility to be open and honest in communicating with patients in order to review the incident and also to report appropriately.

Medical negligence – Human Rights

Human rights must also be considered in the subject of medical negligence. All people have the same rights merely by reason of being human. The right for human dignity (The Universal Declaration of Human Rights – UDHR) should always be respected during the doctor's every encounter with their patients. In fact, medical negligence would be a direct violation to the *right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (International Covenant on Economic, Social and Cultural Rights – ICESCR). Similarly, International Covenant on Civil and Political Rights (ICCPR) states that *no one shall be subjected to torture and cruel, inhuman or degrading treatment*. Furthermore, everyone in the ACT has human rights under the ACT *Human Rights Act*, which is aligned with UDHR, ICCPR and ICESCR.

In conclusion, medical practitioners will continue to be confronted with issues of negligence throughout their career. Mistakes in medical practice can have deleterious effects on the patient and their loved ones, not just immediately, but also long term consequences. This is the inherent nature of medical practice and the reason that the training of a consultant doctor can take over a decade. Doctors are much less likely to be considered negligent if they make clinical decisions based on the care of patients as their first concern and effectively communicating with their patients regarding these decisions. Ultimately, the take-home messages for every doctor is that *Good medical practice is patient-centred and good communication underpins every aspect of good medical practice.*

Lisa (Ching Han) Hsu is a year 3 student at the ANU Medical School. References are available from the author on request.

Adverse events: what to do when something goes wrong:

1. Recognising what has happened.
2. Acting immediately to rectify the problem, if possible, including seeking any necessary help and advice.
3. Explaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences.
4. Acknowledging any patient distress and providing appropriate support.
5. Complying with any relevant policies, procedures and reporting requirements, subject to advice from your medical indemnity insurer.
6. Reviewing adverse events and implementing changes to reduce the risk of recurrence.
7. Reporting adverse events to the relevant authority, as necessary.
8. Ensuring, through the relevant health care complaints commission or medical board.

Source: AMC Good Medical Practice

Medical Board of Australia and AMA join forces on doctors' health

The Medical Board of Australia (the Board) and the Australian Medical Association (AMA) have joined forces on a national health program for doctors and medical students in Australia.

The Board and the AMA have signed a contract for the national delivery of health services to medical practitioners and medical students. The Board will fund the program and a subsidiary company of the AMA, Doctors Health Services Pty Limited (DHS), will ensure nationally consistent services are delivered by service providers in every State and Territory.

The Board will not be involved in the establishment or running of the services, which will:

- be nationally consistent and readily available to all doctors and medical students, no matter where they live
- combine face-to-face health-related triage, advice and referral with telephone help line and online tools and resources where appropriate.

Over time services might expand to also include resilience training and early intervention.

The Board announced in 2014 that it would establish an equitable national health program for doctors and medical students, funded within existing Board resources from registration fees paid by medical practitioners.

Medical Board of Australia Chair, Dr Joanna Flynn AM, said the contract with the AMA marked an important milestone in improving services for doctors with health concerns.

'The Board is committed to supporting the wellbeing of all doctors and medical students in Australia. Creating health services that are accessible and fair to everyone – and are targeted to meet doctors' needs – is a really important contribution we are proud to make,' Dr Flynn said.

AMA President, Associate Professor Brian Owler said that the AMA has strongly advocated for improved access to doctors' health services across the country, and the new arrangements will deliver on that goal.

'The AMA is very pleased to be playing a central role in this project' A/Professor Owler said.

'Critically, the services will remain at arm's length from the Medical Board to ensure that doctors and medical students trust these services and use them at an early stage in their illness' he said.

The national coordination of services will ensure greater consistency in delivery and better use of shared resources such as telephone help lines and web-based tools. These activities will be undertaken by DHS nationally.

DHS will be supported by a part-time officer within the AMA secretariat.

Letter to the Editor

Dear Editor

I wish to respond to the article 'Clinical case study: CT colonography' by Dr Malcolm Thomson in the March 2015 edition of Canberra Doctor.

I thank Dr Thomson for this informative article. I would be grateful if I could offer a counter argument to some of the points made in the article. With regards to CT colonography being 'less costly' than colonoscopy, CT colonography is MBS reimbursable only for patients who have had an incomplete colonoscopy within 3 months, whereas colonoscopy is MBS reimbursable for a broad range of indications. The statement that 'radiation from this procedure is currently believed to be of no significant health risk in the screening population age' is controversial; the risk of radiation-related cancer is potentially increased at a population level, especially if repeated CT scans are performed over time. Younger patients are at particular risk.

Dr Thomson correctly points out that the 'major disadvantage [of CT colonography] is the inability to perform biopsy of any identified lesion'. In fact, this is the fundamental advantage to colonoscopy – polyps can be both detected and excised (not biopsied) using polypectomy at the time of the procedure. Colonoscopic polypectomy has been shown to reduce the risk of mortality due to colorectal cancer (*NEJM*, 2012). 'By definition, a lesion only requires biopsy/review if it is 5mm or larger in diameter' – I am not sure which definition is being alluded to, however smaller lesions will turn into larger lesions over time, and as such all polyps warrant excision even if small. This is the widely accepted standard of care for colonoscopy.

CT colonography would not only miss the majority of these smaller polyps, but also flat polyps such as sessile serrated polyps or even flat colorectal malignancies. Most gastroenterologists performing colonoscopy have an 'adenoma detection rate' between 20% and 40%. As such, the statement that '…over 95% of screening [CT] colonographies performed have no lesion identified requiring biopsy' raises significant concerns about missed pathology. Lastly, most proceduralists have a caecal intubation rate of closer to 98-99%, rather than 90% as stated.

In conclusion, colonoscopy should be the first line investigation for patients with colorectal symptoms and patients who require screening for colorectal neoplasia. CT colonography plays an important complementary role in selected patients (such as those who have failed a conventional colonoscopy, or those with advanced cardiorespiratory comorbidities or advanced age who are poor candidates for sedation), however it is not an appropriate substitute for colonoscopy for the majority of patients.

Yours sincerely,
Dr Arun Gupta, MBBS, FRACP, MD (Melb)
Gastroenterology and Hepatology Unit,
Canberra Hospital
Canberra Gastroenterology,
Deakin

ACCC authorises Medicines Australia code – subject to strengthening individual reporting

The Australian Competition and Consumer Commission is requiring Medicines Australia to strengthen its public reporting as a part of authorising edition 18 of its Code of Conduct (the Code) for five years. The Code sets the standards for the marketing and promotion of prescription pharmaceutical products in Australia by member companies.

In edition 18, Medicines Australia proposed a new reporting regime which requires reporting of 'transfers of value' (such as speaking fees, advisory board fees, or sponsorships to attend a conference) made to individual healthcare professionals. Medicines Australia has also imposed a $120 per meal cap on food and beverages (plus GST and gratuities). Expenditure on food and beverage will not be included in the reporting of transfers of value.

The reporting of payments by Medicines Australia member pharmaceutical companies to healthcare professionals will provide patients and healthcare professionals with some transparency in an area of potential conflicts of interest. Providing broad access to, and scrutiny of, this information could also assist to maintain community confidence in the pharmaceutical industry.

"The ACCC commends Medicines Australia for introducing transparency to payments provided to individual doctors by drug companies," ACCC Commissioner Dr Jill Walker said.

"The ACCC and interested parties have been anticipating this change for a number of years now."

The ACCC accepts that this new transparency regime is a significant and important change to the Code and focuses upon some of the most significant transfers of value.

"Having taken this crucial step, it is important to ensure that the significant benefits of the regime are realised. In this context, the ACCC is requiring the regime to be strengthened to ensure that all relevant transfers of value are reported and that the data is accessible," Dr Walker said.

The ACCC has imposed a condition that enables reporting of all relevant transfers of value. This addresses the ACCC's concern in its draft determination that if a doctor did not consent to the reporting then the individual payment would only be reported in aggregate. It also avoids healthcare professionals withdrawing their consent to reporting their details after receiving a transfer of value. Medicines Australia must amend the Code before 1 October 2016 to require the reporting of all transfers of value.

The ACCC is also requiring the transparency reports compiled by Medicines Australia member companies to be published in a common accessible format and to be available for at least three years. Medicines Australia must also use reasonable endeavours to establish a central reporting system and provide six monthly reports on its progress in doing so. This will ensure that the data collected is accessible to patients and third parties (such as healthcare professionals, consumer and healthcare professional bodies, researchers, academics, and the media) and that the benefits of the new transparency regime are realised.

The ACCC has decided not to require Medicines Australia and its members to continue to report food and beverage expenditure. In reaching this view, the ACCC notes that food and beverage costs are secondary to the more direct transfers of value, a $120 per meal cap applies, and that ongoing reporting would impose a significant administrative burden on member companies.

However if the ACCC becomes aware that the removal of this reporting has led to significant (and unreasonable) increases in food and beverage expenditure, it may reconsider the need for the reporting of this expenditure.

On 17 October 2014, the ACCC released a draft determination proposing to grant conditional authorisation to Medicines Australia for five years, subject to requiring that all relevant transfers of value are reported. On 28 November 2014 a pre-decision conference was held at the request of the RACGP. On 4 December 2014, the ACCC granted interim authorisation to Medicines Australia to allow the continued operation of edition 17 of the code, while the review of edition 18 was underway. In February 2015, the ACCC consulted on five revised proposed conditions of authorisation.

Authorisation does not represent ACCC endorsement of a code. Rather, it provides statutory protection from court action for conduct that meets the net public benefit test and that might otherwise raise concerns under the competition provisions of the Competition and Consumer Act (2010). Broadly, the ACCC may grant an authorisation when it is satisfied that the public benefit from the conduct outweighs any public detriment.

AMA support transparency of relationships

In commenting on the ACCC ruling, President, A/Prof Brian Owler said that the AMA supports transparency of relationships between pharmaceutical companies and health professionals.

"The ACCC's reauthorisation of the Medicines Australia new Code of Conduct increases the transparency of pharmaceutical company activities and provides another mechanism for patients to be informed about their doctor's relationship with individual pharmaceutical companies and therefore able to make informed decisions about their health care.

"We are pleased that the ACCC has provided a twelve month period from 1 October 2015 before for all company-health care professional relationships in certain categories must be reported. Healthcare professionals will only be able to withhold consent for their personal information to be published until 1 October 2016.

"The 'phase-in' period will allow the new public reporting requirements to bed down and become routine: all parties will have the opportunity to understand, plan for, and fully comply with the new requirements.

"The USA experience in implementing new transparency arrangements has not been smooth. Given the likely teething problems with a process that has never before been attempted in Australia, this short delay makes practical sense.

"However the AMA opposes the ACCC's condition that data must be available in a downloadable format so that it can be analysed and reported by others.

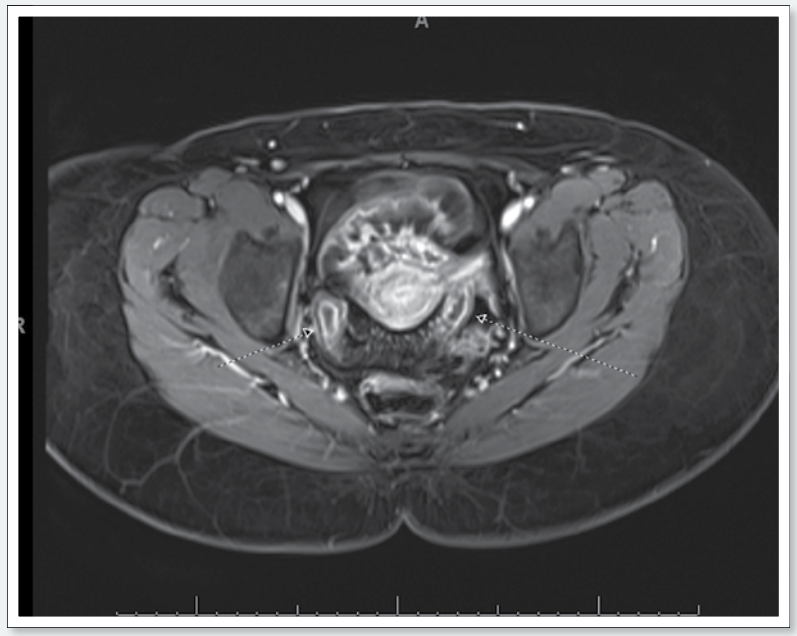
"This data base only needs to allow a prospective patient to search for information on a particular health practitioner who they may be considering for their care. The additional requirements do not benefit individual patients.

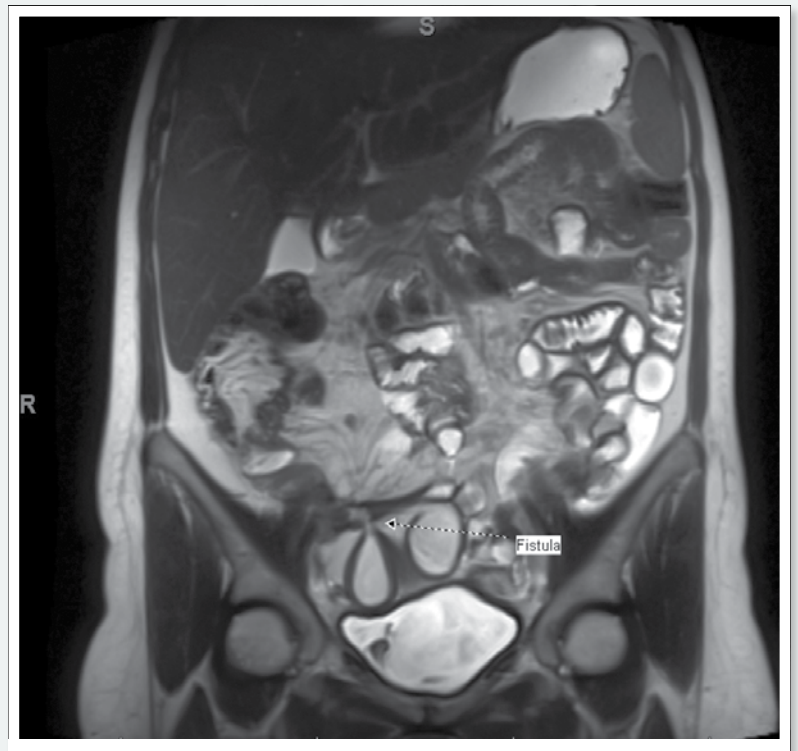
"The AMA looks forward to working with Medicines Australia on a comprehensive education campaign to ensure that medical practitioners are fully informed about the new requirements and expectations.

"AMA's Code of Ethics encourages doctors to provide full disclosure to patients of any financial interests they have in treatments they are recommending", A/Prof Owler concluded.

MR Enterography

Traditionally small bowel follow-through examinations were used for the assessment of suspected small bowel diseases. This method of examination is currently being replaced by cross sectional techniques, such as CT or MR enterography, which allows evaluations of luminal integrity, mural deformity and extraluminal extension of disease.





Actively Inflamed Terminal Ileum with complex Interloop Fistula.

Endoscopic examination of the small bowel either by ileocolonoscopy, double balloon enteroscopy or capsule endoscopy offer the advantage of assessing superficial mucosal abnormalities and obtaining biopsies but may be limited by strictures. Lesion localisation and evaluation may be difficult with capsule endoscopy.

The use of MR enterography has been advocated because of its excellent soft tissue contrast resolution, multiplanar imaging capability and lack of associated exposure to ionizing radiation and iodinated contrast. Traditionally, MR enterography was used for the assessment of inflammatory bowel disease such as Crohns disease. It has also proven useful for the assessment of small bowel polyps (especially patients with small bowel polyposis syndromes), small bowel tumours, coeliac disease and other small bowel related diseases.

In Crohns disease, MR enterography is useful in the assessment of disease activity in an abnormal segment of bowel as this will help direct the treatment for the patient. In addition, it is useful in assessing the entire thickness of the bowel loop, extent of disease and for the presence of skip lesions. Complications of Crohns disease including strictures, fistulae and abscesses are also well assessed. Although the study is not targeted to the perianal region, obvious perianal inflammation/fistulae can be identified. Extraenteric manifestations can also be assessed.

The Procedure:

The patient will be required to fast for four hours prior to the study. No bowel prep is required. Allow at least 2 hours for the procedure.

At the clinic, the patient will drink sorbitol mixed in 2L of water over 90 minutes to distend the small bowel. This can be difficult for the patient to tolerate as it may cause bloating and will result in diarrohea.

The MRI is performed with the patient prone and takes approximately 30 minutes. The study will only be performed when fluid distension of the ileocaecal valve has been achieved. Unenhanced T2 and timed gadolinium enhanced fat suppressed T1 and diffusion weighted sequences are used. Buscopan is administered prior to the contrast enhanced sequences to paralyse the small bowel.

Contraindications:

Inability to tolerate oral contrast, severe claustrophobia and pregnancy. In addition general MRI contraindications such as non MRI compatible implants.

Dr Rohit Tamhane
MBBS FRANZCR
Canberra Imaging Group

Choosing Wisely Australia ® Australia joins the global 'choosing wisely' healthcare revolution

Choosing Wisely Australia launched recently and started a national conversation about more appropriate health care. In a first for Australia, medical colleges and societies have united to take the lead on identifying those tests, treatments and procedures they think are of proven low value or carry an unnecessary risk.

Among the lists are recommendations on food allergy testing, prostate cancer screening, vitamin D screening, monitoring of type 2 diabetes, benzodiazepine prescribing, emergency medicine procedures and ankle and spine imaging.

The initiative is health profession-led and facilitated by NPS MedicineWise.

AMA President, A/Prof Brian Owler welcomed the initiative, launched by NPS MedicineWise, stating that "all doctors are responsible for using their special knowledge and skills to minimise waste of resources, while ensuring that patient care remains their primary duty.

"The involvement of the medical colleges (Australasian College for Emergency Medicine, Australasian Society of Clinical Immunology and Allergy, Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Radiologists sand the Royal College of Pathologists of Australia) in the Choosing Wisely initiative will ensure clinical stewardship and leadership in health care resources, " A/Prof Owler said.

"The AMA is pleased that the criteria for the lists of tests, treatments and procedures are reasonable and transparent.

"This will help build broader public confidence in the initiative, and in the health care system.

"Doctors can work together with their patients to decide on the most appropriate and effective tests, treatments and procedures for the individual patient and their circumstances.

"This is a great start to ensure the best use of health care resources.

"The AMA looks forward to further work with the NPS on this program," A/Prof Owler said.

Choosing Wisely: an international movement

Choosing Wisely began in 2012 in the US as an initiative of the American Board of

Internal Medicine Foundation. The response far exceeded expectations and now more than 60 medical societies have joined and hundreds of evidence-based recommendations have been translated into consumer-friendly language and used by tens of millions of consumers.

The success of Choosing Wisely stems from its unique focus on professional values and patient–practitioner interactions. The movement has gone global with the launch of Choosing Wisely Canada in 2013 and similar initiatives developing in Germany, Italy, Japan, Netherlands and Switzerland, and now also in Australia.

Choosing Wisely Australia

Choosing Wisely Australia is led by Australia's medical colleges and societies and facilitated by NPS MedicineWise. The goal of Choosing Wisely Australia is to start conversations between consumers and clinicians about unnecessary, tests, treatments and procedures, enhancing the quality of care and, where appropriate, reducing unnecessary care.

To raise awareness and embed the principles of this initiative into our health system the objectives of Choosing Wisely Australia are to:

- Encourage clinicians to engage in conversations with consumers about the overuse of tests, treatments and medical procedures.
- Support consumers to make informed choices, in consultation with their clinicians, about getting the right care while limiting exposure to unnecessary tests, treatments and medical procedures.
- Cultivate a culture of responsible stewardship of health care resources among clinicians – from those in medical schools to those in professional practice.
- Engender public dialogue on the issue 'more is not always better' when it comes to medical tests, treatments and procedures.
- Engage health system and non-medical stakeholders, at state/territory and national levels, in the implementation of the Choosing Wisely Australia initiative.

Visit www.choosingwisely.org.au for further information

ACCC acts on NIB health insurance advertising

NIB Health Funds Ltd (NIB) has paid a penalty of $10,200 following the issue of an Infringement Notice by the Australian Competition and Consumer Commission in relation to advertising about the waiver of the waiting period for "Extras" cover.

From December 2012 to November 2014, in promoting its combined Hospital and Extras cover, NIB offered to waive the waiting period on its Extras option which it represented as "usually" or "normally" requiring a 2 month wait.

The Infringement Notice was issued to NIB because the ACCC had reasonable grounds to believe that NIB had contravened the Australian Consumer Law (ACL) by making a false or misleading representation that it usually or normally required a 2 month waiting period for the Extras option, when in fact NIB had made this benefit available to all customers immediately for 23 months from December 2012.

"Consumers should be able to make informed purchasing decisions. Claims that benefits are only available if a product or service is purchased by a specified date must be true and not mislead consumers," ACCC Commissioner Sarah Court said.

"Businesses which extend an offer for a considerable time beyond its original expiry date should ensure that representations made in connection with the offer do not become misleading to consumers as a result."

The payment of a penalty specified in an infringement notice is not an admission of a contravention of the ACL. The ACCC can issue an infringement notice where it has reasonable grounds to believe a person has contravened certain consumer protection laws.

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Caitlin Curry on 0424 191 323 or Lynn Kelly on 0420 970 594

FARE efforts shape Harper Review outcome

Michael Thorn says efforts by FARE to encourage the health sector to respond to the Competition Policy Review process have paid dividends.

National Competition Policy was first introduced in the 1990s and was responsible for much of the relaxation in the regulation of alcohol's availability, impacting on trading hours and outlet numbers in Australia.

Naturally, the announcement in 2014 of a review into competition policy (undertaken by a panel chaired by Professor Ian Harper) was seen by public health advocates as a threat of further deregulation of alcohol controls in Australia.

In response to the announcement, FARE was instrumental in successfully encouraging interested parties and those within the public health sector to join us in making submissions to Professor Harper's review.

As a result of this effort, the Competition Policy Review final report has recognised that alcohol is no ordinary commodity.

On balance, FARE is pleased with the general outcome of the final report. Since releasing its draft report, the Review Panel has significantly shifted their views in relation to alcohol policy, acknowledging both the harms it causes and the need for regulation.

The Panel acknowledged the need for alcohol to be regulated in Australia due to the harm it causes, the importance of harm minimisation as an objective of liquor licensing legislation in Australia, and the need for state and territory governments to be able to set trading hours and planning and zoning controls respective to their needs.

This was a major accomplishment for the combined efforts of the sector and I am confident this will assist significantly in public health efforts to stop the harms caused by alcohol through availability controls.

However not all of the Harper Review findings were favourable.

On harm minimisation, the Panel correctly identified the importance of applying public interest tests to liquor licence legislation. But by arguing that the onus of proof should be placed on those arguing for a public health interest, instead of the applicants, the Harper Review positions a cash-strapped public health sector at a great disadvantage.

Disappointingly, the Panel did not accept that alcohol should not be sold in supermarkets – a measure opposed by FARE on the grounds that increases to the physical and economic availability of alcohol leads to increased alcohol consumption and resultant harms.

Thankfully, rather than simply accept all of the Panel's proposed changes, the Minister for Small Business has instead called for a further round of regulatory review.

This additional consultation means that FARE, along with our colleagues in the health sector, will still have the opportunity to positively influence these reviews.

FARE has produced a comprehensive information brief which assesses the Competition Policy Review final report in greater detail.

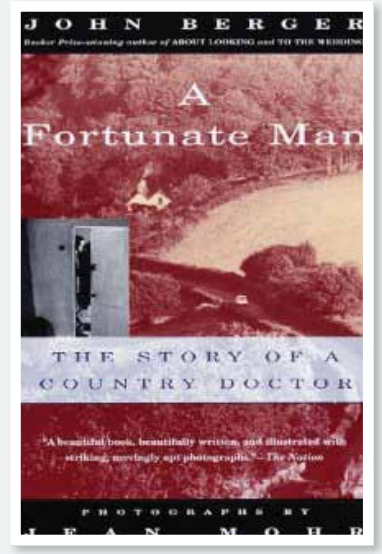
Michael Thorn is Chief Executive of the Foundation for Alcohol Research and Education

Book review: A Fortunate Man

John Berger & Jean Mohr, Canongate, ISBN 978 1 78212 501 4

GBP 14.99

Physicians can be considered fortunate indeed in a vocation that provides insights into the mysteries of human existence. Whether it is to the wayward warp of the flesh or a midnight of the mind, as doctors, we are witnesses.



A Fortunate Man by Berger (author) and Mohr (photographer) describes their embedded experience, in a handsome photo-essay format, within the English country practice of Dr John Sassall. This is a hardback reprint of a book first published in 1967.

Working in an impoverished working class region, Sassall becomes in part a type of existential witness and therapist of travails of the locals. These travails are combinations of physical, psychological or social issues. There is also an undercurrent of ineffable melancholy in the physician's interactions with his patients. Through his vocation, Sassall's persona is both exposed and transformed; he is also troubled by what Berger describes as depressive episodes.

Berger concludes that *"Since we have as yet scarcely begun to establish a society which can assess his contribution socially…."* (p168) Berger then quotes Sassall's own words as to his *Sisphysean* motivation: *"Whenever I am reminded of death – and it happens every day – I think of my own, and this makes me try to work harder."* (p168).

Within the words and pictures of this book are in part the tremendous promise, exactions and perils of general practice, the most challenging of medical specialities, and indeed the practice of the vocation as a whole.

Reviewed by Associate Professor Jeffrey Looi, Academic Unit of Psychiatry and Addiction Medicine, ANU Medical School

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