contactus

Co Editors
Deana Henn, Simon Wooldridge

Medical Editor
Dr Libby Harris, MBBS, FRACGP

News Director
Brad McLean

Political News Editor
Shannon McKenzie

Medical News Editor
Chris Brooker

Clinical Review Editor
Dr Bianca Cannon, B.Med, MBBS (Hons), FRACGP

Staff Reporters
Andrew Bracey
Kirrilly Burton
Catherine Hanrahan
Elizabeth McIntosh
Rada Rouse

Art Director
Rob Millington

Graphic Designer
Melissa Hartley

Pre-Press Coordinator/ Graphic Designer
Saidie Ly

Chief Sub-Editor/Business Editor
Martin Foster

Sub-Editor/Online Editor
Lynda Wilton

Sub-Editor
Robert Santos

Country Manager
Siobhan Murphy

Group Advertising Manager
Frazer Mackenzie-Andrew

Sales Managers
David Cowell
Rose Fulete

PA – Sales & Management
Romina Villanueva

Advertising & Production Manager
Lee Priday

Classified Advertising Manager
Mike Mata

To directly contact staff at Medical Observer email: [first name].[last name]@medobs.com.au

CMPMedica
United Business Media

Medical Observer is published weekly by CMPMedica Australia Pty Ltd, and distributed free of charge to general practitioners and selected specialists.

It is also available on subscription for $350 pa (incl. GST) and overseas rates apply. *Medical Observer* is published 48 times a year.

ABN 68 050 695 157
ACN 050 695 157
ISSN 1445-5560

Sydney office:
Level 2, 1 Chandos Street,
St Leonards NSW 2065
Phone: 02 9902 7777
Fax: 02 9902 7778
Website: www.medicalobserver.com.au
Email: mailbox@medobs.com.au

Printed by Offset Alpine,
42 Boorea St, Lidcombe NSW 2141

™ Certified Environmental Management
ISO 14001:2004 LIC20363
SAI Global
Certification applies to Offset Alpine Printing in Lidcombe NSW

PEFC/xx-xx-xx

Medical Observer is printed on PEFC certified paper, meaning that it originates from forests that are managed sustainably. PEFC is an international certification programme which assures consumers that a forest product can be tracked from a certified, managed forest through all steps of processing and production in the supply chain by a chain of custody process.

Mental health is a yearlong concern

Paul Morgan
Deputy director, SANE Australia

MENTAL Health Week (5-11 October) has just come to an end in Australia and many other parts of the world.

The week is an annual event to promote mental health, running in Australia since 1992 and coordinated by the World Federation for Mental Health and the World Health Organization, and with support from the Australian and state governments. Scores of local mental health organisations in every part of the country promote events in local communities to raise awareness of mental health in general, as well as the needs of people whose lives have been affected by mental illness, and their families.

Events held around the country included a rowing machine race between politicians and athletes in Queensland, a Healthy Mind Festival in Sydney, 4000 promotional chocolates handed out at Brisbane's bus interchanges, celebrations of World Mental Health Day (10 October) at the National Museum in Canberra, and dozens of others. SANE Australia also marked the week by launching a major new DVD kit, *Families and Mental Illness*, in which those affected and their family discuss frankly the effects of symptoms and what helps, and give tips on coping.

If Mental Health Week does anything, it should inspire people to think about mental illness every week of the year

During the week, there were many articles published in the press claiming to 'put the spotlight' on mental illness. However, this begs the question: What happens during the other 51 weeks of the year? Does this one week mean the media feel the issue can be put in the 'done' pile and forgotten until next year when October rolls around?

As GPs and many other health professionals know all too well, mental illness is a 365-day-a-year issue, and the better informed the community is about symptoms and treatments, the more likely people are to seek help early and take an active part in their own recovery.

For one week in October, the information is more prominent. But if Mental Health Week does anything, it should inspire and activate as many people as possible to think about mental illness every week of the year. One in five Australians are affected by mental illness at some stage of their lives, predominantly by anxiety disorders and depression, as well as psychotic disorders. So this is an issue that sooner or later affects everybody, whether directly, as a family member or friend, or indirectly, as an employer, teacher or colleague.

SANE Australia runs a 1800 freecall helpline that helps those one in five and their families, receiving more than 10,000 calls a year from people seeking information and help.

As health professionals, we have the opportunity and obligation to make that information available, accessible and immediate for everyone, every day. Let's not wait for Mental Health Week next year – as the saying goes, there's no time like the present.

Vitamin D and prostate cancer

Associate Professor Phillip Stricker
Director, St Vincent's Prostate Cancer Centre, Sydney

RECENTLY in my book with Professor Kerryn Phelps, *Prostate Cancer for the General Practitioner*, I gave a list of general preventive measures for prostate cancer that highlighted the tenuous evidence in favour of these factors.

One of the factors I mentioned was vitamin D_3, and I would like to draw the attention of the readers to an error in the dosage written in the preventive section as < or = 10,000 IU. It should read < or = 1000 IU.

By way of information, I take this opportunity to update the readers about the potential role of vitamin D as it relates to prostate cancer.

The recommended daily dose of vitamin D has recently increased from 400 IU to 600-1000 IU. One can assess the level of vitamin D one obtains from one's diet, supplementation and sun exposure by a serum 25-hydroxyvitamin D blood level, which should be between 50 and 140 nmol/L. People who are housebound or institutionalised tend to need more vitamin D supplementation due to the lack of sun exposure. It has also been noted that, as people age, they produce less vitamin D from sun exposure.

Vitamin D deficiency has been shown to have a detrimental effect by increasing mortality from life-threatening conditions, e.g. cancer, cerebrovascular disease and diabetes; the jury, however, is still out with regard to its interaction with prostate cancer.

In patients with established prostate cancer, some studies have suggested that doses of up to 4000 IU may suppress the growth of prostate cancer cells.

With regard to prevention of prostate cancer, there is a mixture of evidence, some suggesting that excessive vitamin D may have a detrimental effect and others that inadequate vitamin D may have a positive or a negative effect.

My recommendation, therefore, for patients wishing to prevent prostate cancer, is to follow the general guidelines as per the book *Prostate Cancer for the General Practitioner*.

But in specific reference to vitamin D, I would suggest maintaining a normal serum level of vitamin D in the bloodstream. This would usually be achieved by a daily dose of 600-1000 IU of vitamin D_3.

The level of vitamin D_3 should be adjusted according to serum levels and circumstances. For example, a housebound or institutionalised elderly patient would need more supplementation, up to 1000 IU, whereas lower doses could be used of between 400 and 600 IU in the general population.

The lack of strong evidence for adequate vitamin D in the prevention of prostate cancer should not dissuade people from having an adequate level of vitamin D, as the weight of evidence does suggest that adequate vitamin D levels from diet, supplementation and sun exposure are likely to have a beneficial effect on the overall health of the individual.

For information on posters, pamphlets, books and other resources on mental illness for those affected, their family, friends and the general community, visit **www.sane.org** or contact the SANE Helpline on 1800 18 SANE (7263).

Private billing no answer to mental health crisis

EDITOR: The findings of the report on Better Access to Mental Health Care, by the Senate's Community Affairs Committee, are the predictable results of a fee-for-service approach.

The scheme has resulted in plenty of activity, and there is little doubt that there has been an increase in focus on mental health by GPs and an increase in access to care overall. However, the government will have little idea of the value it's getting for its money in a system where it only gets data about activity and not the content of the activity.

Like the result of the Medicare fee for service for doctors, patients in big cities with lots of doctors or psychologists can access care, but not patients in rural and regional centres, where there is a shortage of workforce. Private billing by most providers reduces access for the disadvantaged.

Patients in big cities can access care, but not those in regional centres

The government also funds divisions to manage psychology services through the Better Outcomes in Mental Health Care (BOiMHC) program. BOiMHC pre-dated Better Access and has been very successful. It addresses the major shortcomings of Better Access. Divisions target the delivery of services to meet gaps in the system. They also provide

comprehensive data regarding activity, content of activity and outcomes.

The government wants to deliver access to care and outcomes to the whole population. This will not happen with fee-for-service models alone, and approaches like BOiMHC are needed.

Dr Mark Foster
Newcastle, NSW

Patients lose if Roxon cuts payments

EDITOR: It is clear that Minister Roxon has some homework to do before she implements her 'pay cuts' for doctors ('Roxon flags GP pay cut for "less complex" work', 3 October).

Firstly, she clearly does not understand that Medicare does not pay doctors. Medicare is a 'non-participatory' scheme, which provides a rebate for patients for the fees that the patient pays to a doctor. In some cases the patient may 'assign' that benefit to the doctor (bulk-billing).

Secondly, if Minister Roxon wishes to consider the relative values of items in the MBS she would do well to study the report of the *Relative Value Study* which was completed at great expense during Minister Wooldridge's time. The study considered the relative value of all items in the MBS, not just items commonly used by GPs. Minister Roxon may like to consider the worth of items billed by specialists as well.

If the rebate means that an item is uneconomic to 'bulk-bill' then a doctor has two options. The first is to bill appropriately and privately for the item and the patient can claim their MBS rebate. Or the doctor may choose not to offer the uneconomic service.

Either way the patient is the loser.

Dr Janet Mould
Garfield, Vic

Health dept should get with the times

EDITOR: The government has done it again! Hot on the heels of Minister Roxon's push to relieve GPs of the burden of 'menial' tasks, we have more red tape foisted upon us!

Almost two years after the HPV vaccination campaign began we finally have a system of central data collection and notification – I guess it's better late than never. Laughably, the system is entirely paper based! A call to the HPV register confirms that there is no process for electronic transmission of information.

It is truly ironic that the medical profession has to endure hectoring from the minister about restructure and reform when she is unable to drag her own department out of the stone age. As I have said before to the Department of Health and Ageing: Get with it! We at the coal face are in the 21st century, it's about time you guys got out of the 19th century.

Dr Peter Meggyesy
Sorrento, Vic

Stock market takes tips from 'medical bonds'?

EDITOR: Regarding the financial crisis, how did the money market cotton on to our strategies?

They have been selling derivatives, a kind of bet sold as insurance related to a future event such as a company developing financial difficulties or "a financial heart attack".

They have marketed this by cleverly telling companies that they are all at risk, even though this is not true, as many companies will never have a financial crisis.

I thought that we had this strategy to exploit for ourselves. We have long been selling "medical insurance bonds", such as the group known as statins. By telling everyone they are at risk of a heart attack, we can sell them a bond in the medical futures market. No need for them to know that less than one in 20 will benefit from buying these bonds, so long as holding onto it is important for them.

Selling the bonds increases our turnover, and at least they walk away with a tablet to take, unlike our financial colleagues, who have to convince investors to part with their money for a piece of paper of variable worth. We have science behind us that allows us to take this gamble on their behalf.

The old HRT futures bond is no longer worth the paper it is written on and no longer doing business. Fortunately, there are many products that we can sell, such as the PSA or CA 125 futures bond. My plan is to sell the PSA futures bond to women to use in case they meet a man in the future.

At least our saving grace is that unlike our financial colleagues who have to deal with Congress, we have surreptitiously gotten our public funding through via the Medical Futures Rescue Fund (alias Medicare).

Dr Mark de Souza
Adamstown, NSW

write to letters

Post: Medical Observer, Locked Bag 3000, St Leonards, NSW 1590 **E-mail:** mailbox@medobs.com.au **Fax:** 02 9902 7778
Website: www.medicalobserver.com.au Letters should be no longer than 200 words and must include contact details.