Letters

(Ir)responsible drinking campaigns

To the Editor: The alcohol industry invests in "responsible drinking" advertisements purportedly designed to meet corporate social responsibility objectives. Analysts have proposed that such advertising is used to avoid alcohol control measures and in effect constitutes alcohol promotion.[1-4]

The Australian alcohol industry organisation DrinkWise recently launched an online video advertisement, "How to drink properly", which has been seen by tens of thousands of viewers. To investigate young drinkers' responses, we conducted a qualitative study with 40 Western Australian drinkers aged 18–21 years. A research agency recruited the sample members from among young people listed in its large database, who were sent an invitation email to ascertain whether they drank alcohol. Eligible respondents were then sent an email in March 2014 containing an internet link to the video and an open-ended request to "Let us know your reactions to this video". The participants responded by reply email. Data were analysed using NVivo 10 (QSR International). The responses were coded according to attitudinal (eg, like/dislike the ad) and behavioural intentions variables. The study was approved by the Curtin University Human Research Ethics Committee.

Around two-thirds of respondents reported liking the ad, describing it as "cool", "classy" and "clever". It was viewed as specifically targeting their age group: "The message was clearly targeting younger drinkers, perhaps in their teens and 20s"; "You can tell it is solely focused on the younger demographic"; and "It seemed as though it was talking to me and my friends, rather than the whole community". Reasons given for this perception included creative elements (cartoon format, humour, swearing) and recognition of heavy drinking practices: "It accepts that people drink and get 'shitfaced', as the ad says". Some noted that the ad stimulated desire: "It immediately encouraged me to drink".

Overall for this sample, the take-out message was that drinking is a normal part of life with distinct advantages if undertaken at "appropriate" levels. No respondents nominated the number of drinks required to achieve this level. Some commented that they were aware of the need to avoid excessive consumption, but that it is difficult to stop once drinking has commenced. There was no demonstrated understanding of the National Health and Medical Research Council guidelines, which note that young people up to the age of 25 "are at particular risk of harm from alcohol consumption".[5]

Our study findings suggest that through its "responsible drinking" advertising, DrinkWise instead risks effectively promoting alcohol consumption to 18–21-year-olds. Of considerable concern is that people aged under 18 are also highly likely to be exposed to this advertisement, given its online placement.

Simone Pettigrew Research Professor, School of Psychology and Speech Pathology

Mike Daube Professor of Health Policy

Nicole Biagioni Research Associate

Faculty of Health Sciences, Curtin University, Perth, WA.

simone.pettigrew@curtin.edu.au

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> "It accepts that people drink and get 'shitfaced', as the ad says"
>
> Pettigrew et al

Liaise with pathologists to refine understanding of the prostate-specific antigen test

To the Editor: We are pleased to see Sikaris and colleagues agree with our concerns about the prostate-specific antigen (PSA) screening controversy, particularly overdiagnosis and inadequacies of the PSA test.[1] However, we disagree with their conclusions about the value of PSA screening, which imply that the criticisms we raised[2] can be neutralised if other PSA testing processes are used. The Royal College of Pathologists of Australasia (RCPA) position appears to be based on assuming that the European Randomized Study of Screening for Prostate Cancer[3] is valid while the other major trials are flawed. However, this is cherry-picking, as there are no less serious potential methodological flaws in the European trial — with different clinical management of the controls and screened cancers which could account for better screened outcomes[4] — than with the other trials.

We also disagree with Sikaris et al's proposal that pathologists offer information about the PSA tests with medians for age group to test-ordering doctors, coupled to the RCPA recommendations for a baseline PSA test at age 40 years.[5] Age-adjusted PSA medians may, or may not, be predictive of prostate cancer screening outcomes. Before widescale adoption in clinical practice, this strategy first needs thorough evaluation by empirical testing — together with a number of other refinements of screening, such as new prostate cancer markers[6] and magnetic resonance imaging.[7]

Christopher B Del Mar Professor of Public Health[1]

R Gordon Wright Professor of Pathology[1]

Paul P Glasziou Professor[2]

1 Faculty of Health Sciences and Medicine, Bond University, Gold Coast, QLD.

2 Centre for Research in Evidence-Based Practice, Bond University, Gold Coast, QLD.

gwright@bond.edu.au

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In reply: It is interesting that in the debate on prostate cancer screening, positions are not as far apart as a "debate" implies. I agree with Del Mar and colleagues that all the existing trials have "serious potential methodological flaws" and therefore cannot be taken as evidence that prostate-specific antigen (PSA) screening is effective — nor that it is ineffective. Both sides of the "debate" are consistent with the recent National Health and Medical Research Council conclusion that PSA testing may help some men and may not help others.

Numerous studies have shown that age-related medians significantly predict prostate cancer outcomes,[1-5] and therefore the experts advising the Medicare Benefits Schedule have supported follow-up of PSA levels above the median. While I am also hopeful that new markers for detection will be found, in the interim, in the realm of pathology testing, no better approach than PSA-based testing is available. While magnetic resonance imaging may offer significant advantages (and at a cost), I would leave this potential for my medical imaging and urology colleagues to sort out, as it is outside my area of expertise.

Kenneth A Sikaris Chemical Pathologist,[1] and Associate Professor[2]

1 Melbourne Pathology, Melbourne, VIC.
2 University of Melbourne, Melbourne, VIC.

ken.sikaris@mps.com.au

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Difficult but necessary conversations — the case for advance care planning

To the Editor: The Royal Australian College of General Practitioners (RACGP) noted with interest the two articles published in the *Medical Journal of Australia*[1] and *MJA InSight*[2] that promoted advance care planning (ACP) and end-of-life care discussions as an important element of everyday clinical practice for Australia's GPs.

The RACGP is an advocate for ACP and end-of-life care discussions at a primary health care level. It is in general practice that ongoing and trusted patient relationships are developed, placing GPs in an optimal position to initiate and promote ACP. Awareness and acceptance of ACP has grown considerably over the past decade as evidence in support of its benefits has continued to emerge.[3-5] As medicine has expanded from offering "cure" to include the management of chronic and incurable conditions, the importance and prevalence of ACP have increased.

In recognising the important role that Australia's GPs play in the promotion and delivery of ACP, the RACGP developed a position statement in 2012 encouraging the integration of ACP into routine practice. The RACGP continues to draw on and promote this position in its discussions with government, thought leaders and the general practice profession at large.

> "age-related medians significantly predict prostate cancer outcomes"
>
> Sikaris

The RACGP concurs with the challenges detailed in the *MJA* article and is committed to providing its members with the knowledge and skills required to have these sensitive and sometimes difficult conversations. The RACGP has launched an online education module via *gplearning* to assist GPs in further developing skills in the delivery of ACP and end-of-life care discussions.

The RACGP will remain an advocate for the incorporation of ACP and end-of-life conversations into routine general practice and is committed to providing Australian GPs with the education and skills necessary for confidently and appropriately managing these conversations and patient's concerns.

Liz Marles President

Royal Australian College of General Practitioners, Melbourne, VIC.

liz.marles@racgp.org.au

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The hidden issues of anticipatory medications in community palliative care

To the Editor: Most people, because of the "normality" it offers, wish to die at home.[1] Additional interconnected factors, including preferences, functional status and caregiving responsibilities,

contribute to achieving this desire.[2] Key to the inability to stay at home is lack of symptom control, frequently resulting in hospital admission.[3]

A recent Australian Institute of Health and Welfare report[4] shows that about $3 million was paid for medications in the palliative care schedule (about $158 per patient). The report noted a 42% increase in benefits for palliative care schedule items from 2007 to 2012; in particular, a 107% increase for analgesics.

While this trend requires further analysis, what is unknown is how much medication is prescribed as emergency or anticipatory medications. The prescription of such medications ensures availability in anticipation of symptoms that may arise for people receiving care at home.[5] Medications are prescribed by a general practitioner or treating specialist, for administration by community nurses in response to assessment of potentially inadequately controlled symptoms. Together with signed orders, medications are generally kept in the patient's home; although, anecdotally, policy and practice relating to storage (including Schedule 4 and 8 medications) vary widely. This availability means nursing staff have the capability to minimise symptoms, often enabling the person to stay at home for longer, and reducing emergency hospital admissions.[5] The availability of anticipatory medication is consistent with good palliative care, an exercise in forward planning.[6]

However, an audit at Melbourne City Mission Palliative Care, a community-based palliative care service, found that anticipatory medications were used in less than 20% of cases. If this is indicative of the general usage of anticipatory medications throughout the country, would there not be a more cost-effective system of drug availability, such as the licensing of nurses to carry a limited equivalent of a doctor's bag? And what of the disposal of the medications not used? To our knowledge, there is no systematised way of returning unused medications to the pharmacy. These issues require further research and costing of an efficient and safe system, with delineated procedures for administration, storage and disposal, for delivering anticipatory medications without disadvantaging those who wish to be cared for and to die at home.

Margaret O'Connor Vivian Bullwinkel Chair in Palliative Care Nursing,[1] and Research Consultant[2]

Susan Gatens Clinical Nurse Specialist[2]

Brian H Le Medical Consultant,[2] and Unit Head[3]

1 School of Nursing and Midwifery, Monash University, Melbourne, VIC.

2 Palliative Care, Melbourne City Mission, Melbourne, VIC.

3 Department of Palliative Care, Royal Melbourne Hospital, Melbourne, VIC.

margaret.oconnor@monash.edu

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Removing the interview for medical school selection is associated with gender bias among enrolled students

To the Editor: Wilkinson and colleagues report sex bias in two components of widely used methods of selection of students for graduate entry to Australian medical schools.[1] They argue for more equitable methods to ensure that selected "cohorts … should be representative of the communities from which they are drawn". In focusing on sex equity in particular, they neglect the prime responsibility of medical schools to produce graduates to meet national workforce needs.

Australia has obvious workforce problems. Among these are the shortage of doctors in rural and remote areas, the paucity of Indigenous doctors, the rise in specialisation at the expense of generalists, the increased reliance on overseas-trained doctors to staff the public sector and, most cogently for this discussion, the significantly diminished workforce contribution of women doctors (who work, on average, 40% less throughout their careers than do men).[2]

> "availability of anticipatory medication is consistent with good palliative care"
>
> O'Connor et al

> "Where is the evidence that equitable selection based on population demographics produces desirable workforce outcomes?"
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> Arnold

Where is the evidence that equitable selection based on population demographics produces desirable workforce outcomes? The range of attributes needed to practise the diversity of modern medicine is broad. In the absence of an obvious single panacea for "optimal" selection of "a good doctor", perhaps we need more diversification in admission policies?

Of course, some will argue that selection based on particular workforce issues smacks of social engineering; others will ask whether or not there is any evidence that selection, by any method, improves workforce outcomes. Perhaps, to them, a lottery commends itself.[3] What could be more equitable? At least, it would enrich the mix of those admitted under current selection policies.

Expensive medical education is largely subsidised by the public purse. Surely aiming to address the abovementioned workforce issues with cost-effective solutions should be a major consideration in selection policy rather than a focus on equity between the sexes.

Peter C Arnold Retired General Practitioner

Sydney, NSW.

parnold@ozemail.com.au

Competing interests: Two of my three daughters are doctors married to doctors.

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Rural clinical school outcomes: what is success and how long do we wait for it?

To the Editor: The main criterion for the success of any rural clinical school (RCS) should be a substantial proportion of graduates in the rural health workforce after completing postgraduate training. As RCS graduates comprise only 25% of all Commonwealth-supported medical school places, RCSs on their own will never meet the needs of the 32% of the Australian population in rural areas;[1] and it is impossible to compel, and unreasonable to expect, all RCS graduates to enter rural practice. A target of 50% of RCS graduates in rural practice would seem ambitious but not inappropriate, given the level of financial support for the RCS program. However, targeted and actual outcomes may differ, depending on the location of RCS training and future regional employment options. For example, the demographics and locations of RCS training are very different in rural Western Australia (substantially outer regional and remote) compared with rural Victoria (substantially inner regional).

Assessing outcomes takes time. The minimum time from graduation to completion of training ranges from 4 years (for general practice) to 6–10 years (for other specialties), but is often longer because of delays occasioned by indecision, lack of access to training positions, and delays during training (eg, parental leave). The question then is how long after graduation should we wait before assessing the workplace location of RCS graduates.

We compared January 2013 and January 2014 practice location data for graduates from the Melbourne Medical School RCS.[2] For the 47 graduates from 2006, there was an encouraging 58% increase in those practising in a rural location (Australian Standard Geographical Classification – Remoteness Areas 2–5).[3] In graduating years 2007–2013, the proportion in rural practice varied from 13% to 33% and showed either no change or a decrease in rural location of practice over the 12-month period.

The recent increased numbers in rural practice of the 2006 graduates is encouraging in terms of desired RCS outcomes, and is consistent with the predicted time delay (> 7 years) required before assessing the success of the RCS program.

William R Adam Professor of Medicine[1]

Julian R Wright Director of Medical Student Education and Professor of Medicine[1]

Geoffrey J McColl Director of Medical Student Education and Professor of Medicine,[1] and Director[2]

1 Rural Health Academic Centre, University of Melbourne, Shepparton, VIC.

2 Medical Education Unit, University of Melbourne, Melbourne, VIC.

wadam@unimelb.edu.au

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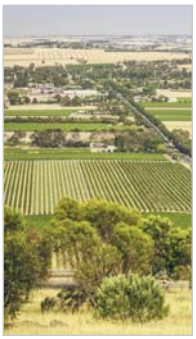
Rural, urban: the real world for medical education

To the Editor: I read with interest the article by Hamilton, which refers to the difficulties and inequities faced by the disadvantaged in urban communities.[1] Hamilton notes that Flinders University pioneered rural medical education programs last century. It may interest readers to know that the university is now pioneering urban longitudinal community-based medical education.

The Onkaparinga Clinical Education Program (OCEP) is a 1-year program for third-year graduate-entry medical students.[2] It is based in an outer suburban area of Adelaide, where there are local government areas that are among those with the lowest socioeconomic status in South Australia.[3] Established in 2009, the OCEP provides an urban community-based program for 24 medical students to work for a full year in the community in general practices, local community hospitals and local specialists' practices. For the first 6 months, students are based in a general practice for two to four sessions per week. They also attend the emergency department at Noarlunga Hospital (a 100-bed community hospital) for one or two sessions per week, and a range of specialist and community clinics for one or two sessions per week. In the second 6 months, students undertake 4-week rotations in medicine, surgery and psychiatry at Noarlunga Hospital, augmented by sessions at private specialist consulting clinics. As Noarlunga Hospital does not provide obstetric or inpatient paediatric services, students undertake these components at Flinders Medical Centre (4 weeks for each component). Lectures, tutorials and skills training are provided throughout the whole year at the OCEP in a purpose-built facility opposite Noarlunga Hospital.



> "students also work with disadvantaged adolescents at the local secondary school"
>
> Mahoney

As part of the OCEP's commitment to social accountability, students also work with disadvantaged adolescents at the local secondary school.[4] The OCEP is working with the school to develop a wellbeing centre based in the school, where medical students will work with adolescents (under supervision) to provide near-peer health advice, counselling, and assistance with referral to mainstream services.

A formal evaluation will be carried out in 2014. However, to date, the program has developed with regular feedback and evaluation from students and clinicians, and academic results have been at least equivalent to those of students at other Flinders University sites.

Sarah Mahoney Academic Coordinator, Onkaparinga Clinical Education Program

School of Medicine, Flinders University, Adelaide, SA.

sarah.mahoney@flinders.edu.au

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