

Letters

Digitising the *Medical Journal of Australia* — a centenary gift to the nation

TO THE EDITOR: Just as the juxtaposed centenary of the First World War is creating intense national and international interest, the centenary of the *Medical Journal of Australia* is an excellent opportunity to delve into the history of Australia's health. The Journal has recently published historical articles and photographs, often informing readers about forgotten stories. It is the national repository of invaluable information about health care and medical research, with related editorials, medical biographies and much more. While articles selected by the Journal's editorial staff undoubtedly raise interest, much greater scope for historical and genealogical research would be satisfied if all issues of the Journal were digitised.

Early issues of the printed Journal are accessible in major libraries and universities in capital cities, but these are much less readily available in new medical schools, to international scholars and for the general community.

More than 200 years ago, the first issue of the *New England Journal of Medicine and Surgery* (now *New England Journal of Medicine*) had as its first article "Remarks on angina pectoris" by John Warren.¹ This and all subsequent articles are now available online. Online access to other major medical journals dates back to issues published from October 1823 for *The Lancet*, October 1840 for the *Provincial Medical and Surgical Journal* (now *BMJ*) and July 1883 for the *Journal of the American Medical Association*.

Here in the Antipodes, selected articles published in the *Medical Journal of Australia* since January 1996 are available online. Since January 2002, whole issues have been available online to subscribers. Complete issues of the *Australian and New Zealand Journal of Surgery*

(from June 1931), *Australian and New Zealand Journal of Medicine* (now *Internal Medicine Journal*; from February 1971) and the *New Zealand Medical Journal* (from November 1999) are available as e-journals.

Access to these e-journals and their online format varies. For many, selected articles are free but access to other articles requires a subscription or payment. All are available through university libraries to academic staff and students.

The National Library of Australia provides extraordinary and free access to a veritable treasure-trove of major city and regional newspapers.² For example, all issues of the *Sydney Morning Herald* from 1842 to 1954 can be searched online.

As a valued service to its regular readers and a gift to historical researchers and family historians, not only in Australia but worldwide, it is timely for the Journal to digitise its vast centenary of issues, either alone or in partnership with the National Library of Australia.

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1 Warren J. Remarks on angina pectoris. *N Engl J Med Surg* 1812; 1: 1-11. <http://www.nejm.org/doi/pdf/10.1056/NEJM181201010010101> (accessed Jun 2014).

2 National Library of Australia. Trove [website]. <http://trove.nla.gov.au> (accessed Jun 2014). □

IN REPLY: We thank Lancaster for his compliments and for expressing an interest in the digitisation of the Journal's back issues. We fully endorse such a proposal and agree that the complete digitisation of the Journal would make publicly (and instantly) available a unique historical record of Australian medicine. This is also critical, because the print collection is ageing: the pages and spines of the early volumes are crumbling and this will eventually lead to loss of the collection.

We have been working on this project since 2007. Negotiations have included the National Library

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of Australia and other parties. Unfortunately, we have yet to find an affordable solution. Philanthropic funding has been sought but has so far been unavailable. We call out to all potential donors to extend their assistance to ensure this valuable resource survives well beyond its first century.

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Copayments for general practice visits

TO THE EDITOR: While the points made by Del Mar¹ would have their proponents and opponents, it is a pity that the debate is constrained by Australia's obsession with universal fee-for-service medical care.

Surely we should be rational and have "horses for courses". If there are socioeconomic areas (whether urban or rural) where most people would be seriously deterred from seeing a general practitioner by a \$6 (or \$7) copayment, is it reasonable or logical for medical practice in those areas to be remunerated on a fee-for-service basis?

Fee-for-service has a purpose — to make patients bear some responsibility for their use of medical services.

Such impoverished areas could instead be served (and in many countries are served) by salaried GPs or by GPs paid per patient on their books (capitation).

Health insurance mitigates the fee-for-service burden on patients but, if excessively generous, leads to the "moral jeopardy of insurance", where the patient spends at will, knowing that the insurer is picking up the tab.

Is it not time for Australia to give up this obsession with *universal* fee-for-service? It has proven to be unbearably expensive for the nation,

aggravated by Medicare's and health funds' (backed by federal subsidy) reimbursements.

Let's find a rational solution to our nation's budgetary woes, not an emotional one.

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1 DelMar CB. Copayments for general practice visits [editorial]. *Med J Aust* 2014; 200: 367. □

IN REPLY: Arnold regrets that the debate about copayments is restricted to fee-for-service methods of paying general practitioners.

This is true. The Minister for Health has intimated an overhaul of the whole general practice system, but this was not addressed in the recent federal Budget. This is a pity. It would be good to have a debate about different systems, ranging from our current blended model of fee-for-service with grants to practices for achieving quality indicators, through to capitation systems (eg, the United Kingdom's National Health Service) and salaries (common in public hospitals and in primary care in some countries).

Perhaps this is also a good moment to try to bridge the great divide between state health (mostly hospitals) and federal health (mostly general practice and private health care), which obstructs much of integrated care.

Tinkering at the edges with copayments seems too trivial.

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Dear Minister, please save yourself from activity-based funding

TO THE EDITOR: There must be a better way of funding public hospitals than basing it on historical spending without analysis of activity or outcomes.

The opinion by Stoelwinder describes some of the politics

and history of health funding in Australia, and argues against activity-based funding (ABF),¹ suggesting that innovation is stifled in such a funding model and that "less intrusive population funding" would be preferable. The reasons for these assertions are unclear.

ABF has been the basis of funding of private hospitals in Australia for many years. The counting method is the diagnosis-related group (DRG) system that is well established and regularly revised and updated. It is transparent and accountable, and it is reasonable to apply the method to public hospitals also. When applied properly it has the potential to limit "gaming".

Stoelwinder implies that outcome measures could be used, but these are controversial and challenging to develop and it is not yet practical to apply these as a currency for funding. The Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority (IHPA) are working jointly on options for incorporating safety and quality factors into ABF modelling, although implementation will take some time.

The funding of health care is complicated by politics. Whether or not Australia has a single funding model in the future — something that would be potentially more efficient than the complex federal system that we have currently — the work of the IHPA in developing robust methods underpinning ABF will be of enduring value. ABF is the most appropriate currently available method of funding hospitals.

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Competing interests: I am the Chair of the Clinical Advisory Committee to the Independent Hospital Pricing Authority.

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1 Stoelwinder JU. Dear Minister, please save yourself from activity-based funding. *Med J Aust* 2014; 200: 200. □

IN REPLY: Gough has missed the central argument in my article,¹ which is not against activity-based funding (ABF) per se, but against the federal government's use of it.

ABF facilitates hospital *technical* efficiency (cost per patient treated),

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Is it not time for Australia to give up this obsession with *universal* fee-for-service?

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Arnold

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The funding of health care is complicated by politics

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Gough

as the Victorian public hospital experience will attest. However, it is arguably counterproductive to achieving *allocative* efficiency (optimal distribution of health services for greatest community benefit). It incentivises more hospital care.

ABF is a tool for purchasers of hospital services and, when used by private insurers, as Gough notes, it acts as a framework for negotiating prices that take into account different hospital cost structures and market positions. It is not formula funding.

I suggest the federal government fund state governments on a risk-adjusted population formula, facilitating allocative efficiency (with a focus on health outcomes) and reducing its own financial risk and administrative cost.

This would allow the states more service flexibility and would facilitate innovation in systems of care to deal with growing demand. States can still use ABF as a tool to drive technical efficiency when purchasing public hospital services.

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1 Stoelwinder JU. Dear Minister, please save yourself from activity-based funding. *Med J Aust* 2014; 200: 200.

Renal replacement therapy associated with lithium nephrotoxicity in Australia

TO THE EDITOR: Roxanas and colleagues¹ overemphasise the relative risks of renal replacement therapy (RRT) with lithium treatment. Based on the most recent Australian defined daily dose statistics, about 1150 people per million population are taking lithium,² and the incidence rate for RRT is ≤ 0.78 cases per million population per year.¹ Therefore, in Australia, the risk of requiring RRT is $< 1/1470$, which is considerably lower than that in Sweden ($1/187$).^{1,3} The prevalence of patients taking lithium in Australia did not change from 1995 to 2010,² meaning that the reported increase in patients requiring RRT over

that period¹ is more likely due to other factors, such as changes in diagnostic categorisations,¹⁻³ or other medications.

Against this low risk of RRT, lithium, when compared with other pharmacological treatments, reduces the risk of suicide, self-harm and manic relapse in patients with major affective disorder.⁴ The number needed to treat to avoid one suicide is about 50.⁴ This means that for each person in whom RRT is avoided by cessation of lithium ($< 1/1470$ treated), up to 30 could be predicted to have committed suicide, and a larger number could be predicted to have a manic relapse or to self-harm.

The challenge is to predict the patients with lithium nephropathy who are likely to require RRT, given the lack of certainty of diagnosis or renal prognosis for such patients.^{1,3,4} Certainty about a progressive decline in renal function attributable to lithium may take some years in patients with substantial fluctuations in renal function over time,⁵ making informed consent to cease lithium particularly difficult because of the substantial psychiatric benefits.⁴

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Competing interests: No relevant disclosures.

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- 1 Roxanas M, Grace BS, George CRP. Renal replacement therapy associated with lithium nephrotoxicity in Australia. *Med J Aust* 2014; 200: 226-228.
- 2 Australian Government Department of Health. Australian statistics on medicines 2011. <http://www.pbs.gov.au/info/browse/statistics> (accessed Jun 2014).
- 3 Bendz H, Schon S, Attman P, Aurell M. Renal failure occurs in chronic lithium treatment but is uncommon. *Kidney Int* 2010; 77: 219-224.
- 4 Adam WR, Schweitzer I, Walker RG. Trade-off between the benefits of lithium treatment and the risk of chronic kidney disease. *Nephrology* 2012; 17: 776-779.
- 5 Al-Aly Z, Balasubramanian S, McDonald JR, et al. Greater variability in kidney function is associated with an increased risk of death. *Kidney Int* 2012; 82: 1208-1214.

TO THE EDITOR: The article by Roxanas and colleagues¹ is a welcome addition to the body of literature that clearly demonstrates a causal relationship between lithium use and chronic renal failure. The recommendation to monitor renal function 6-monthly and be hypervigilant to deteriorating renal function is sound clinical advice.



I suggest the federal government fund state governments on a risk-adjusted population formula



Stoelwinder

However, I question the recommendation that clinicians should consider stopping lithium and using other suitable mood stabilisers (eg, sodium valproate) if two consecutive readings suggest decrease in renal function, or if the estimated glomerular filtration rate is < 45 mL/min/1.73 m².

I believe it is more clinically prudent to refer patients who have deteriorating renal function to a nephrologist, who can determine the cause.

I do this routinely and two trends have emerged. The first is that most but not all individuals who are taking lithium and who have deteriorating renal function have interstitial fibrosis, the putative renal abnormality caused by lithium.

When individuals with interstitial fibrosis are switched from lithium to other mood stabilisers, many have a stormy clinical course and never achieve the mood stability they had previously experienced with lithium.

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Competing interests: No relevant disclosures.

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- 1 Roxanas M, Grace BS, George CRP. Renal replacement therapy associated with lithium nephrotoxicity in Australia. *Med J Aust* 2014; 200: 226-228.



The challenge is to predict the patients with lithium nephropathy who are likely to require RRT



Adam

IN REPLY: We welcome valuable comments in response to our article on lithium and end-stage renal disease (ESRD).¹ This is an area that warrants further discussion and additional data. Our study, the first comprehensive epidemiological analysis of the link between lithium nephropathy and ESRD in any country, indicated a progressive increase in the problem in Australia between 1991 and 2011.

We have had difficulty determining whether this increase was due to increased lithium use, given that ESRD is usually associated with prolonged exposure (typically 20 years or more) and that complete data on lithium use in Australia are only readily available since 1995.

We accept that lithium is often an effective mood stabiliser that only sometimes causes toxicity. However, we believe that prescription of a

drug that can propel people toward permanent dialysis or transplantation requires caution. We therefore applaud Saboisky's practice as a psychiatrist of conjointly managing patients with a nephrologist. We do similarly.

We also endorse the call for more accurate diagnosis of renal disease, especially as bipolar disorder is often associated with risk factors such as smoking, obesity and poor diet. Our study showed that few patients with suspected lithium-induced kidney disease undergo renal biopsy, and we suggest that nephrologists could consider modifying this deficiency.

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1 Roxanas M, Grace BS, George CRP. Renal replacement therapy associated with lithium nephrotoxicity in Australia. *Med J Aust* 2014; 200: 226-228. □

Telehealth for motor neurone disease

TO THE EDITOR: Telehealth is an expanding area with emerging evidence of use in the management of motor neurone disease (MND) and home mechanical ventilation.¹⁻³ Here, we report our experience with the use of telehealth for managing MND in Queensland.

MND is a devastating disease with affected patients having an average life expectancy of 2-3 years. Progressive muscle weakness leads to the loss of speech and ability to swallow, inability to use arms and legs and, eventually, respiratory failure. Patients are usually reviewed in specialised outpatient clinics at major Australian tertiary hospitals.⁴ However, as the disease advances, MND patients find it difficult to attend these clinics because of advanced disability.

As in other centres in Australia, in Brisbane, the Royal Brisbane and Women's Hospital (RBWH) and, separately, The Prince

Charles Hospital (TPCH) have multidisciplinary MND clinics that involve medical, nursing and allied health staff. Since 2008, a monthly MND telehealth clinic has been conducted (using a dedicated bandwidth, average 768 kbps) for patients across Queensland and northern New South Wales. Thirty-eight patients have been seen, an average of three times at 3-4-monthly intervals. This has meant that the patients have been followed for about 12 months beyond the last tertiary hospital visit. The average driving distance from Brisbane per telehealth event was 612 km (range, 158-1824 km). The local service was based in hospitals or community health services, with multiple-site login to the RBWH (MND clinical nurse consultant, neurologist and palliative care physician) and TPCCH (sleep physician and sleep nurse).

The major problems addressed at telehealth consultations were symptom-based, dominated by the respiratory and palliative concerns. Practical support was provided for general practitioners for managing symptoms (such as excess saliva, immobility and communication problems), the use and withdrawal of non-invasive ventilation, and end-of-life support.

The advantages of telehealth over traditional outpatient clinics include the continued support by personnel who are experienced in MND. Skype and other technologies would allow even greater access, but have issues of confidentiality and security. Telehealth may also reduce the sense of hopelessness that MND patients feel: there is something intangibly positive about finishing a consultation with "so should we make an appointment for 3 months time?"

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Competing interests: No relevant disclosures.

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1 Vitacca M, Assoni G, Pizzocaro P, et al. A pilot study of nurse-led, home monitoring for patients with chronic respiratory failure and

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prescription of a drug that can propel people toward permanent dialysis or transplantation requires caution

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Telehealth may also reduce the sense of hopelessness that MND patients feel

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with mechanical ventilation assistance.

J Telemed Telecare 2006; 12: 337-342.

2 Vitacca M, Comini L, Tentorio M, et al. A pilot trial of telemedicine-assisted, integrated care for patients with advanced amyotrophic lateral sclerosis and their caregivers. *J Telemed Telecare* 2010; 16: 83-88.

3 Nijeweme-d'Hollosy WO, Janssen EP, Huis in 't Veld RM, et al. Tele-treatment of patients with amyotrophic lateral sclerosis (ALS). *J Telemed Telecare* 2006; 12 Suppl 1: 31-34.

4 Kiernan MC, Talman P, Henderson RD, et al. Establishment of an Australian motor neurone disease registry. *Med J Aust* 2006; 184: 367-368. □

Australian doctors and the war

TO THE EDITOR: Mervyn Archdall, reflecting on his Great War experience, wrote in 1941 that military doctors' "first consideration must always be the filling of gaps in the combatant ranks".¹ How relevant is this statement to the modern Australian Defence Force (ADF)?

The role of the Royal Australian Army Medical Corps remains "to contribute to the Army's operational capability through the conservation of manpower".² The Royal Australian Navy and Royal Australian Air Force are less prosaic but have similar intent. However, every ADF doctor is a non-combatant and remains obliged to treat all patients (including enemy combatants) equally and with primary regard to welfare rather than operational capability.³ For example, in a recent ADF operation, an enemy combatant suffered blast amputation of the hands and penetrating eye wounds when the improvised explosive device he was planting detonated. An ADF doctor performed lifesaving surgery, and the combatant was then evacuated for ophthalmic care.

Potential tension between the role of the organisation and that of its doctors is not dissimilar to a public hospital wanting to contain costs, in which doctors struggle to provide the "best care" to every patient. As in civilian health care, the theoretical tension is rarely problematic because, in reality, both civilian hospitals and ADF military hospitals want to achieve the best care for every patient. In the ADF, this is explicitly codified: "Medical personnel ... cannot be ... compelled to carry out any act incompatible with their humanitarian mission or medical

ethics".⁴ Further, the ADF "must care for the wounded, sick or shipwrecked members of enemy armed forces taken prisoner in the same way as [it does] for [its] own personnel".⁵ Modern ADF health care therefore emulates civilian best practice, with clinical governance and peer review ensuring that prioritisation of operational capability does not occur at the expense of individual patient welfare.

In another marked departure from earlier times, ADF casualties requiring physical or psychological rehabilitation are encouraged to continue to serve and contribute to ADF capability to the extent that

this is possible — an embodiment of what the British term the "military covenant".

There may be a civilian lesson in the modern military approach. Explicit recognition of professional ethics within a civilian health care system that must also contain costs might become increasingly valuable if civilian doctors are to remain their patients' advocates rather than merely employees of "the system".

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There may be a civilian lesson in the modern military approach



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Competing interests: I am a serving officer in the ADF. doi: 10.5694/mja14.00734

- 1 Archdall M. Australian doctors and the war [editorial]. *Med J Aust* 1941; 1 (18): 553-554.
- 2 The Australian Army. The Royal Australian Army Medical Corps. <http://www.army.gov.au/Who-we-are/Corps/The-Royal-Australian-Army-Medical-Corps> (accessed Jun 2014).
- 3 Neuhaus S, Bridgewater F, Kilcullen D. Military medical ethics: issues for 21st century operations. *Aust Def Force J* 2001; 151: 49-58.
- 4 Australian Government Department of Defence. Law of armed conflict. Australian Defence Doctrine Publication 06.4. Canberra: Defence Publishing Service, 2006.
- 5 International Committee of the Red Cross. Summary of the Geneva Conventions of 12 August 1949 and their additional protocols. 2nd ed. Geneva: ICRC, 2012. □