
The Parliament of the Commonwealth of Australia

Treating impotence

Roundtable forum on impotence medications in Australia

House of Representatives
Standing Committee on Health and Ageing

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Foreword

The committee hopes this report highlights some of the challenges in the area of treating and managing erectile dysfunction (ED), and that it moves the debate some way forward to addressing those issues.

Treating ED early presents a significant opportunity to treat and perhaps prevent chronic diseases such as cardiovascular disease and diabetes. This early detection helps the patients concerned and can play a part in preventative health, as well as easing the costs on the Australian health system as a whole. Accordingly, I urge all men suffering ED to see a general practitioner for a comprehensive check-up.

Finally, on behalf of my committee colleagues, I would like to thank everyone who participated in the inquiry by appearing as witnesses or presenting submissions.

Steve Georganas MP
Chair



Membership of the committee

Chair Mr Steve Georganas MP

Deputy Chair Mr Steve Irons MP

Members Mr James Bidgood MP (*to 22/10/09*) Mrs Julia Irwin MP
Mr Mark Coulton MP Ms Catherine King MP
Mrs Joanna Gash MP Mrs Margaret May MP
Ms Jill Hall MP Ms Amanda Rishworth MP

Membership of the sub-committee

Mr Steve Georganas MP, Chair

Mr Steve Irons MP, Acting Chair

Ms Amanda Rishworth MP

Committee secretariat

| | |
|-------------------------|--------------------|
| Secretary | Mr James Catchpole |
| Inquiry Secretary | Ms Penny Wijnberg |
| Administrative Officers | Mrs Fiona McCann |
| | Mr Shaun Rowe |



Terms of reference

The Committee will hold a roundtable forum to examine the health impacts of impotence medications in Australia.

The Committee is concerned that some of these medications, which are legally available for sale, may not be clinically tested and may have adverse impacts on men's health and wellbeing. The Committee also has concerns that medical advice in respect of these medications is being offered to consumers over the telephone in lieu of a face-to-face consultation with a medical practitioner.



List of abbreviations

| | |
|--------|---|
| ABS | Australian Bureau of Statistics |
| ACP | Australian Custom Pharmaceuticals |
| AMI | Advanced Medical Institute |
| ED | Erectile dysfunction |
| GP | General practitioner |
| MATeS | Men in Australia Telephone Survey |
| NCCTG | National Co-ordinating Committee on Therapeutic Goods |
| PSA | Pharmaceutical Society of Australia |
| RACGP | The Royal Australian College of General Practitioners |
| STI | Sexually transmitted infection |
| TG Act | <i>Therapeutic Goods Act 1989</i> |
| TGA | Therapeutic Goods Administration |
| USANZ | The Urological Society of Australia and New Zealand |

Introduction

- 1.1 Several members of the committee have recently become concerned at practices that have developed to treat and manage erectile dysfunction (ED) in Australia. Their concern has arisen as a result of being approached in their electorates by men with complaints about their treatment. The main complaint of these men was the contractual practices of commercial ED clinics, which require men sign to contracts for treatment regimens that are only able to be cancelled under specific conditions.¹
- 1.2 However, what prompted the committee to hold a public hearing was concern about the potential affect that the practices of commercial ED clinics may have on men's health more broadly. The risk is that men treated for ED are not being screened for some of the common causes of ED including diabetes and cardiovascular disease.²
- 1.3 The committee determined that a single roundtable forum would be the best manner in which to conduct an inquiry of this nature, as it would afford an opportunity to gather interested individuals around the table to discuss the issues and recommend potential solutions.

What is erectile dysfunction?

- 1.4 ED, which is sometimes called impotence, refers to the inability of men to achieve or maintain an erection that allows sexual penetration.³ It affects a large number of men, with studies showing that 40 percent of men aged
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1 AMI rejects this allegation, details of their response can be found in Submission No. 13, p 15.

2 Andrology Australia viewed on 19 October 2009 at <http://www.andrologyaustralia.org/pageContent.asp?pageCode=ERECCAUSES>.

3 Andrology Australia viewed on 19 October 2009 at <http://www.andrologyaustralia.org/pageContent.asp?pageCode=ERECFACTS>.

over 40 experience some level of ED and that the figure is as high as 70 percent of men aged over 70.⁴ However, there is in fact a lack of definite data on the number of men affected as Professor Marshall informed the committee:

The Florey Adelaide Male Ageing Study has been following 1,000 men for nearly five years now, and they have all had questions about erectile function. These men are aged from 35 to 80 and 57 percent of those men have already reported that they have some issues with erectile dysfunction. This obviously indicates that there is likely to be an even greater incidence than the figure that we heard earlier this morning, of one in five, from Andrology Australia.⁵

1.5 The most common cause of ED is ageing,⁶ but at the roundtable the committee heard evidence that ED can be an early marker for chronic, lifestyle and other diseases such as cardiovascular disease, diabetes, depression excessive use of alcohol, smoking, prostate problems, neurological disorders, hormone imbalances and the side effects of other medications and stress.⁷

1.6 This report focuses on the treatment of ED. A related condition is that of premature ejaculation which refers to the inability to control the timing of ejaculation and therefore ejaculating before one is ready:⁸

Premature ejaculation is the most common male sexual problem and affects men of all ages. Premature ejaculation is more common in younger men, as they are often less sexually experienced or secure with the situation in which they are having sex.⁹

1.7 ED and premature ejaculation are separate conditions which require different treatments. However, while the roundtable has focussed on the treatment of ED, many of the concerns about ED treatments also apply to

4 Eli Lilly Australia, Submission No. 1, p 1.

5 Marshall, V., Freemasons Foundation Centre for Men's Health, Transcript, p 13.

6 Eli Lilly Australia, Submission No. 1, p 1.

7 Fitzsimons, M., Medicines Australia, Transcript, p 23; Marshall, V., Freemasons Foundation Centre for Men's Health, Transcript, p 13; Doyle, R., Advanced Medical Institute, Transcript, p 28; The Royal Australasian College of Physicians, Submission No. 7, p 1; Pfizer Australia, Submission No. 11, p 2.

8 Andrology Australia viewed on 19 October 2009 at <<http://www.andrologyaustralia.org/pageContent.asp?pageCode=PREFACTS>>.

9 Andrology Australia viewed on 19 October 2009 at <<http://www.andrologyaustralia.org/pageContent.asp?pageCode=PREFACTS>>.

the treatment of premature ejaculation as they are often treated by ED clinics using the same, or similar, methods.

Treatment options

- 1.8 There are many options available for men who are experiencing ED including pharmaceuticals, counselling, the use of external devices and surgery.¹⁰ Andrology Australia's website outlines the main types of treatments and these include:
- **Non-invasive** treatments such as:
 - ⇒ oral medications for example Viagra®, Cialis® and Levitra®; and
 - ⇒ external devices such as rubber rings and vacuum devices.
 - **Injectable** treatments such as:
 - ⇒ penile injections for example Caverject®.
 - **Surgical** treatments such as:
 - ⇒ penile prosthesis; and
 - ⇒ vascular surgery.¹¹
- 1.9 The treatments provided by many commercial ED clinics, such as the one of the largest providers in Australia the Advanced Medical Institute (AMI),¹² are different from those outlined above. AMI treats ED using one or more of the following; nose sprays, gel applications, lozenges or penile injections.¹³ Their products are specifically formulated for each patient using different mixtures of ingredients that have already been approved by the Therapeutic Goods Administration (TGA).¹⁴ Making specific medication for an individual patient is known as extemporaneous compounding and is discussed in greater detail in chapter 2.
- 1.10 The committee does not have the expertise to make judgements about competing claims of the efficacy of different ED treatments. AMI has presented evidence to the committee demonstrating the efficacy of the

10 Eli Lilly Australia, Submission No. 3, p 1.

11 Andrology Australia viewed on 19 October 2009 at <<http://www.andrologyaustralia.org/pageContent.asp?pageCode=ERECTREAT>>.

12 Doyle, R., Advanced Medical Institute (AMI), Transcript, p 3.

13 AMI viewed on 19 October 2009 at <<http://amiaustralia8-px.rtrk.com.au/page/17/Treatment-Information>>.

14 AMI viewed on 19 October 2009 at <<http://amiaustralia8-px.rtrk.com.au/page/4/Why-AMI>>.

ingredients in its compound formulations, which others question.¹⁵ The concerns of the committee in this report are how the treatments are prepared and how they are prescribed. Finally, the committee is not endorsing any particular method of treatment over another. Specific advice about treatment for ED should be sought from a qualified medical practitioner.

The roundtable

Parameters of report

- 1.11 This is a report of a roundtable forum and draws together the evidence received at the roundtable, and in subsequent submissions, to reach conclusions about the practice of prescribing ED treatment in Australia today.
- 1.12 The committee is aware of complaints to consumer and regulatory bodies about the contractual and advertising practices of commercial ED clinics. The report will not focus on these practices. Nevertheless, issues around contracts are a significant problem, one which AMI itself acknowledges. At the roundtable, AMI stated that 75 percent of the complaints it received were contractual complaints.¹⁶ The committee received a submission from Legal Aid Queensland detailing significant contractual issues that they had sought to resolve on behalf of their clients. The committee is concerned that by expecting patients to sign a treatment contract they are prevented from getting their money back should the treatment not work. Of particular concern are examples of financial hardship endured by consumers who were unable to cancel their contract with AMI, or who were told that they faced significant health risks, including death, if they failed to undertake treatment for ED.¹⁷ The committee urges AMI to reconsider its contracting procedures, to make it easier for patients to cease treatment should they so wish.
- 1.13 Chapter 2 contains the committee's discussion and is structured around 4 themes which are:
 - the extent of men's interaction with the health system;

15 See for example: Exhibit No. 15; Exhibit No. 39; Exhibit No. 44; Exhibit No. 45; Exhibit No. 46; Malouf, D., Urological Society of Australia and New Zealand (USANZ), Transcript, p 9.

16 Doyle, R., AMI, Transcript, p 51.

17 See Legal Aid Queensland, Submission No. 10.

- the appropriateness of using telemedicine as a first option for prescribing;
 - the adequacy of the regulations governing the sale of ED medications; and
 - the integration of commercial ED clinics with the proposed e-record system.
- 1.14 The committee has not made recommendations in the report. However, the committee has made its comments and opinions clear throughout the report, and will be presenting the issues raised in this report to Parliament and the Minister for Health for consideration.
- 1.15 The report makes significant reference to AMI which, as mentioned, is the largest and most prominent commercial ED clinic. In fact, AMI was the only commercial ED clinic to attend the roundtable forum and make a submission. The committee accordingly thanks AMI for participating in the proceedings and responding to its critics.

Conduct of roundtable

- 1.16 The roundtable was conducted around two discussion topics; diagnosis and medication, and regulation of the provision and sale of impotence medication. The discussions sought to consider the size and extent of the market for ED treatment, the different types of ED treatment, the health issues that are related to ED and the regulation of the treatment of ED in its various forms.
- 1.17 The committee selected a number of organisations which would be able to give a broad range of views and represent diverse interest groups including those representing pharmacists, medical practitioners, commercial ED clinic providers and consumers. The participants in the roundtable discussion, which was held in Canberra on Friday, 21 August 2009, were as follows:
- Advanced Medical Institute;
 - Andrology Australia;
 - The Freemasons Foundation Centre for Men's Health;
 - Impotence Australia;
 - Medicines Australia;
 - Pharmaceutical Society of Australia;

- The Royal Australasian College of Physicians, Chapter of Sexual Health Medicine;
- The Royal Australian College of General Practitioners;
- SHine SA;
- Therapeutic Goods Administration;
- Dr Patricia Weerakoon, Coordinator of the Graduate Program in Sexual Health, University of Sydney; and
- The Urological Society of Australia.

1.18 In addition to the roundtable, the committee accepted as evidence 15 submissions from interested persons or organisations, and a further 57 exhibits. These are listed in appendices B and C.

1.19 The committee would like to extend its thanks to all of the individuals and organisations that travelled to Canberra to participate in the roundtable discussion, or made submissions to the inquiry.

1.20 The committee took in-camera evidence from a person who had been a customer of various commercial ED providers. The person gave a personal and client perspective to the evidence taken at the roundtable. The committee thanks the person for having the courage to talk with the committee.

Issues and conclusions

- 2.1 Some of the current practices employed to sell or prescribe impotence medications in Australia have raised concerns amongst healthcare professionals, consumer advocates and the general public. Much of the criticism is directed at the practices of commercial erectile dysfunction (ED) clinics, although many of the concerns also apply to the selling of impotence medication online.
- 2.2 This chapter examines four of the major issues related to the health impacts of the sale of impotence medications in Australia that were discussed at the committee's roundtable. They are:
- the extent of men's interaction with the health system;
 - the appropriateness of using telemedicine as a first option for prescribing;
 - the adequacy of the regulations governing the sale of ED medications; and
 - the integration of commercial ED clinics with the proposed e-record system.

Men's interaction with the health system

- 2.3 The Federal Government is currently seeking to reorient the health system towards a greater focus on the prevention of serious chronic disease. This focus is evidenced by the commissioning and subsequent report of the National Preventative Health Taskforce strategy *Australia the healthiest*

country by 2020.¹ The strategy proposes ways to prevent diseases associated with alcohol, tobacco and obesity. This committee also has an interest in preventative health, having previously convened an inquiry into obesity in Australia and investigated the benefits of prevention as a means to cut costs to the health system and to improve the lives and health of Australians in general.

- 2.4 There is now emerging evidence that ED is a marker of chronic health problems, including cardiovascular disease and diabetes.² There will, therefore, be long-term benefits for men's health and the health system generally if ED diagnosis can be treated in a preventative health context.

Do men visit their General Practitioner?

- 2.5 Anecdotal evidence suggests that men are not proactive about maintaining their good health and therefore do not regularly visit a general practitioner (GP) to discuss their health, including their sexual health.³ However, evidence given at the roundtable suggests that this anecdotal advice is somewhat misleading, and that men - particularly those over 40 years of age - are more likely to visit a GP than is imagined.
- 2.6 The committee heard from Professor Handlesman, who represented Andrology Australia at the roundtable, that the Men in Australia Telephone Survey (MATeS) found that the men surveyed did indeed visit a GP.⁴ That survey asked men questions focusing mainly on their reproductive health but also on a broad range of questions about lifestyle, sexual behaviour and general health. The MATeS study suggests that almost 90 percent of men aged 40 and over visit a GP at least once a year. The study was conducted in 2003 and was the:

... first whole-of-nation, population-based study focusing on the reproductive health and other problems of middle-aged and older Australian men.⁵

- 2.7 The MATeS study found that:

1 The National Preventative Health Taskforce viewed on 19 October 2009 at <<http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/national-preventative-health-strategy-11p>>.

2 Marshall, V., Freemason's Foundation Centre for Men's Health, Transcript, p 13.

3 Vartto, K., SHine SA, Transcript, p 16.

4 Handlesman, D., Andrology Australia, Transcript, p 21.

5 de Krester, D., et al, *The Men in Australia Telephone Survey (MATeS) – lessons for all* viewed on 19 October 2009 at <http://www.mja.com.au/public/issues/185_08_161006/dek10080_fm.html>.

... men expressed high levels of concern about developing reproductive health problems as they age: 80 percent were concerned about developing erectile dysfunction, and 57 percent about developing prostate cancer.⁶

- 2.8 However, the MATeS study also identified that men are selective about the topics which they choose to raise with their doctor. Mr Doyle, a representative of the Advanced Medical Institute (AMI), informed the committee that evidence from the MATeS study indicated that only one third of patients raise their ED with a GP. He added that:

There are a number of reasons why people do not want to speak to their GP about this issue. Firstly ... that many doctors were uncomfortable taking a sexual history. Secondly ... that men are very embarrassed about their condition ... men do not believe that their family GPs understand what the impact is of ED on their lives.⁷

- 2.9 Other witnesses argued that embarrassment alone does not deter men from seeking appropriate medical assistance. The committee heard that men do present to clinics that treat sexually transmitted infections (STIs), which are also embarrassing conditions. Mr McCann from Impotence Australia explained that men present to STI clinics because men accept that STIs are a medical problem and because the clinics are specialised and only treat STIs.⁸

- 2.10 GPs are the health system's "gatekeepers" - intended to assess the totality of their patients' health, to refer them to specialists if necessary and to encourage patients to adopt preventative health strategies. The committee accepts that patients do visit GPs. However, the fact remains that there is a demonstrable consumer demand for commercial ED clinics and the services they provide. Men approaching these clinics instead of a GP may therefore be missing out on the holistic health care advice they require. The challenge is to identify and reduce the barriers that make men reluctant to discuss sensitive health problems face to face with a GP.

6 de Krester, D., et al, *The Men in Australia Telephone Survey (MATeS) – lessons for all* viewed on 19 October 2009 at

<http://www.mja.com.au/public/issues/185_08_161006/dek10080_fm.html>.

7 Doyle, R., Advanced Medical Institute (AMI), Transcript, p 26.

8 McCann, B., Impotence Australia, Transcript, p 31.

What are men's experiences of the health system?

- 2.11 Treating ED when men do present to a GP is made more difficult by the fact that there is a general lack of health literacy in the Australian population. Health literacy is a basic level of knowledge which enables a person to "obtain, process and understand" health information to enable them to make good quality health decisions.⁹ Dr Pinskiier from the Royal Australian College of General Practitioners (RACGP) informed the committee that Australian Bureau of Statistics (ABS) data suggests that 60 percent of Australian men have insufficient health literacy to properly understand a medical consultation when they do go for one.¹⁰
- 2.12 The committee also heard from Professor Marshall from the Freemasons Foundation Centre for Men's Health that evidence from a study they are conducting is showing that when men do visit a GP they are dissatisfied and do not feel like they have had an adequate opportunity to properly discuss their health concerns. He conceded that there is also a limited understanding in the medical profession about the best ways to achieve a satisfactory interaction between patients and the health profession more broadly.¹¹
- 2.13 Finally, the MATeS study stressed the need to understand the "social, cultural and environmental influences" that drive men's health seeking behaviour and reluctance to raise some issues with their GP.¹²

What improvements are needed?

- 2.14 Discussions among health professionals arising out of the MATeS study have canvassed ways to reduce the barriers that make it difficult for GPs and patients alike to discuss ED:

In a clinical setting, these barriers need to be overcome by allowing men, particularly older men, opportunities to disclose reproductive health concerns that may otherwise remain unspoken. Health promotion strategies that address men's health concerns may assist in overcoming barriers to help-seeking behaviour. Examples include targeted health education sessions

9 National Network of Libraries of Medicine viewed on 19 October 2009 at <<http://nmlm.gov/outreach/consumer/hlthlit.html>>.

10 Pinskiier, N., The Royal Australian College of General Practitioners (RACGP), Transcript, p 46.

11 Marshall, V., The Freemasons Foundation Centre for Men's Health, Transcript, p 29.

12 de Krester, D., et al, *The Men in Australia Telephone Survey (MATeS) – lessons for all* viewed on 19 October 2009 at <http://www.mja.com.au/public/issues/185_08_161006/dek10080_fm.html>.

and promotional displays as part of other social events, such as community men's health nights, and workplace or local community events.¹³

- 2.15 The committee was also interested to learn the opinions of roundtable participants about ways to better equip GPs to discuss ED, in particular with men.
- 2.16 Dr Patricia Weerakoon coordinates the Graduate Program in Sexual Health at the University of Sydney which is designed to train health professionals and develop their expertise in the specialised area of sexual health.¹⁴ She stated that, historically, training in sexual health has not been a priority, even in the best medical training programs, and that:
- ... the fact that [ED] is an early marker for lifestyle and for many diseases is fairly new research and it has been picked up fairly recently.¹⁵
- 2.17 Dr Pinskiier from the RACGP explained that doctors could be trained to better deal with men's health conditions, including ED, through already established training processes:
- There is a well-established process for postgraduate GP education. If there is an issue around the education and capacity of general practitioners to deal with that then we need to sort that out. We have well-developed educational training processes and a well-distributed network through the divisions of general practice, which is funded by and large by the Commonwealth.¹⁶
- 2.18 Several other ways of improving ED treatment were also canvassed at the roundtable, including better training of all health professionals (not just GPs), educating men about the underlying causes of ED and improving the amenity of GP surgeries so that they are more welcoming to male patients.¹⁷
- 2.19 AMI informed the committee that half of its business was done through its clinics, and these have been specially designed to cater for the unique needs of its patients. For example, Mr Doyle stated that AMI clinics have

13 de Krester, D., et al, *The Men in Australia Telephone Survey (MATEs) – lessons for all* viewed on 19 October 2009 at http://www.mja.com.au/public/issues/185_08_161006/dek10080_fm.html.

14 Graduate Program in Sexual Health viewed on 19 October 2009 at http://www.fhs.usyd.edu.au/sexual_health/about/index.shtml.

15 Weerakoon, P., University of Sydney, Transcript, p 16.

16 Pinskiier, N., RACGP, Transcript, p 37.

17 Marshall, V., The Freemasons Foundation Centre for Men's Health, Transcript, p 29.

individual waiting rooms so that men are not forced to sit in a public area while waiting for their consultation:

That is a very important issue to these men. They do not want to run into friends, acquaintances or anyone else.¹⁸

2.20 The Federal Government has recognised that the maintenance of men's health requires a specific approach and is developing a National Men's Health Policy that:

... will focus on reducing the barriers men experience in accessing health services, tackling widespread reticence amongst men to seek treatment, improving male-friendly health services, and raising awareness of preventable health problems that affect men.¹⁹

Committee comment

2.21 There is emerging evidence about the link between ED and serious underlying conditions such as cardiovascular disease and diabetes. These conditions represent a significant cost to the health care budget and are targeted as part of the Federal Government's focus of preventative health.

2.22 Accordingly, the committee believes that the health system collectively needs to better identify ED as an early warning for more serious conditions. That however, requires health professionals to create the conditions that make men more comfortable seeking help for ED and then for any underlying conditions.

2.23 The committee thinks that there is value in implementing a targeted public health campaign to better inform men about underlying conditions for which ED may be an early marker. This campaign should educate men about the need for those who experience ED to seek advice from a medical practitioner in order to ensure that any serious health issues are identified early.

2.24 Commercial ED clinics exist because there is a demand for the services they provide. These clinics are effective because they make it as easy as possible for men to seek treatment for ED. The downside, discussed in greater detail below, is that the clinics treat ED in isolation and are not as effective in identifying other, underlying conditions that should be targeted in a preventative health strategy.

18 Doyle, R., AMI, Transcript, p 30.

19 National Men's Health Policy, viewed on 19 October 2009 at <<http://www.health.gov.au/menshealthpolicy>>.

- 2.25 General practitioners are ideally placed to identify any underlying health issues that may be manifesting at an early stage. However, by definition, general practitioners, do not have the luxury of being able to specialise, as ED clinics do, in talking to men about their sexual health. As part of an effective preventative health strategy though, the capacity of health care professionals to treat and manage ED should be strengthened and the barriers that men face when discussing sensitive health conditions should be addressed and reduced as much as possible. This will enable men to feel comfortable seeking treatment for ED through their GP.

Is telemedicine appropriate?

- 2.26 One of the significant criticisms levelled at commercial ED clinics such as AMI is their use of telemedicine as a vehicle to prescribe pharmaceuticals to patients. Telemedicine is the use of technology, such as telephone and video conferencing, to connect doctors with patients.²⁰
- 2.27 The committee recognises that there is a legitimate role for telemedicine to play in providing health services in Australia, particularly rural and remote Australia. Nevertheless, the committee is worried about the use of telemedicine as a routine prescribing service. Dr Pinskier from the RACGP stated that the practice of telemedicine is to provide advice and not prescribe medication:
- There is some telemedicine that occurs around the country that is well accepted, particularly around nurse call centres ... What they are not doing at the end of the day is selling medication. They are prescribing advice. They are advice lines only.²¹
- 2.28 A risk of telemedicine is that it makes it difficult for doctors to detect and manage lifestyle factors associated with ED through a telephone consultation.²² Roundtable participants stressed the importance of face-to-face consultations and stated that these should serve as the minimum standard for ED treatment.²³ Dr Weerakoon from the University of Sydney argued that:

20 NSW Health viewed on 19 October 2009 at http://www.chw.edu.au/parents/telehealth/nsw_health_consumer_telehealth_brochure.pdf.

21 Pinskier, N., RACGP, Transcript, p 46.

22 Malouf, D., USANZ, Transcript, p 19; Fitzsimons, M., Medicines Australia, Transcript, p 23.

23 See Handlesman, D., Andrology Australia, Transcript, p 34.

If GP's with all their medical training and other health professionals, nurses, rehab counsellors, none of them are indicating that they feel comfortable or have the knowledge to talk about it, I seriously doubt that somebody at the end of a telephone line can really have the training to be able to detect and manage lifestyle factors and early markers for diseases.²⁴

- 2.29 AMI responded that there were a number of reasons why telemedicine suited its patients, including the anonymity of the service and the fact that men do not need to present to a pharmacy to collect their medication.²⁵ AMI further added that while 50 percent of its current patient load was treated using telemedicine,²⁶ some of the telemedicine involves a video consultation.²⁷ In fact, AMI submitted that using technology based consultations may actually improve the number of men seeking treatment for their condition.²⁸
- 2.30 In response to criticism at the roundtable that medicine was prescribed over the telephone by individuals who are not doctors, AMI was emphatic that:
- No-one can obtain a treatment without speaking to a properly qualified doctor.²⁹
- 2.31 The committee also acknowledges that AMI encourages all patients to visit a GP for a general health check to deal with any health issues other than ED which may be present.³⁰ Nevertheless, this does not mean that the patients do so.
- 2.32 The committee sought advice about the regulations surrounding the use of telemedicine in Australia. Professor Marshall from the Freemasons Foundation Centre for Men's Health indicated that establishing guidelines for telemedicine is very complex and difficult to achieve, particularly when the provision of care crosses jurisdictional boundaries.³¹
- 2.33 Mr Doyle from AMI stated that:

24 Weerakoon, P., University of Sydney, Transcript, p 15.

25 Doyle, R., AMI, Transcript, p 26. The AMI submission further details the benefits of technology based consultations. See Submission No. 13, p 4.

26 Doyle, R., AMI, Transcript, p 34.

27 Doyle, R., AMI, Transcript, p 34.

28 AMI, Submission No. 13, p 5.

29 Doyle, R., AMI, Transcript, p 27.

30 Doyle, R., AMI, Transcript, p 28.

31 Marshall, V., The Freemasons Foundation Centre for Men's Health, Transcript, p 42.

For telephone consultations there is a national standard that applies to all telemedicine, which all medical practitioners are required to comply with.³²

2.34 Others felt that the National Policy for Technology Based Consultations to which Mr Doyle referred does not specifically mention prescribing.³³ The National Policy for Technology Based Consultations, which has been adopted by the medical boards in all the states and territories, outlines principles to which medical practitioners who utilise technology consultations should adhere. To comply with the principles a doctor should:

- Include an adequate assessment of the patient's condition, based on the history and clinical signs and appropriate examination.
- Keep colleagues well informed when sharing the care of patients.
- Make their identity known to the patient.
- Ensure they communicate with the patient to establish the patient's current medical condition and history, and concurrent or recent use of medications, including non-prescription medications; identify the likely cause of the patient's condition; ensure that there is sufficient clinical justification for the proposed treatment; ensure that the proposed treatment is not contra-indicated. This particularly applies to technology-based consultations where the practitioner has no prior knowledge and understanding of the patient's condition(s) and medical history or access to their medical records.
- Be ultimately responsible for the evaluation of information used in treatment, irrespective of its source. This applies to information gathered by a third party who may have taken a history from, or examined, the patient.
- Be confident that a direct physical examination would not add important information to inform their treatment decisions or advice to the patient. This particularly applies to consultations where the practitioner has no prior knowledge or understanding of the patient's condition(s) and medical history or to access to their medical records.
- Make appropriate arrangements to follow the progress of the patient by monitoring the effectiveness and appropriateness of the recommended

32 Doyle, R., AMI, Transcript, p 49.

33 McMahon, C., The Royal Australasian College of Physicians, Transcript, p 45.

treatment and by informing the patient's general practitioner or other relevant practitioners.³⁴

- 2.35 AMI rejects the need for face-to-face consultations to diagnose and treat either premature ejaculation or ED. Their submission refers to the American Urological Association guidelines on the treatment of premature ejaculation which states that it is a diagnosis based on sexual history alone. Further, in relation to ED, AMI claims that there is a divergence of opinion as to whether or not a physical examination is necessary to diagnose ED. They submit that the Boots pharmacy in the UK dispenses Viagra without a prescription and therefore no consultations with a medical practitioner.³⁵
- 2.36 Another issue with the use of telemedicine to treat ED is that patients may not be aware of who their doctor actually is. The committee thinks that AMI should do more to ensure that patients have continuity of care. This means that AMI should endeavour to ensure that a patient knows the name of the treating doctor, and that, where possible, any follow-up is undertaken by the same treating doctor. The committee recognises that this may be difficult to achieve, but there would be significant benefits in ensuring, as much as possible, that a patient speaks to the same doctor each time they call. It is easy to understand how people can be confused about whether or not they are speaking with a doctor when they deal with more than one AMI employee in the course of a single telephone consultation.³⁶
- 2.37 A number of witnesses at the roundtable criticised AMI for not prescribing globally recognised first-line treatments for ED,³⁷ or presenting patients with the option of undertaking psychological counselling.³⁸ The committee argues that it is incumbent on AMI doctors to present patients with the full range of treatment options for ED, given that AMI is often the first point of call for men who are experiencing ED. It is not sufficient for AMI to simply assess whether or not a patient is a suitable candidate for AMI treatment options. There is a risk that if the AMI treatment fails to correct a patient's ED then the mental health of that patient will be adversely affected because they are not aware of the many other treatment options open to them and therefore think that they will have ED for the rest of their lives.

34 New South Wales Medical Board, Exhibit No. 5.

35 AMI, Submission No. 13, p 5.

36 Doyle, R., AMI, Transcript, p 27.

37 Malouf, D., USANZ, Transcript, p 18.

38 Spierings, D., Impotence Australia, Transcript, p 14.

Committee comment

- 2.38 The committee questions whether commercial ED clinics which prescribe medication over the telephone can be complying with all the principles of the National Policy for Technology Based Consultations. In particular, given emerging evidence about the links between ED and chronic disease, commercial ED clinics cannot “be confident that a direct physical exam would not add important information to inform their treatment decisions of advice to the patient” as is required under the guidelines. Without such a direct physical exam, detection of chronic conditions such as heart disease and diabetes will be next to impossible.
- 2.39 Notwithstanding AMI’s concerns that limiting the use of telemedicine based treatment would limit the options of men seeking treatment for ED,³⁹ the committee believes that it is inappropriate to use telemedicine to prescribe any new treatment to patients unless absolutely necessary. There are a number of benefits of telemedicine in Australia, including its use as a tool to provide advice to patients and perhaps to provide repeat prescriptions. However, the practice of prescribing medication to a previously unknown patient based on a relatively short telemedicine consultation as a first and routine option should, in the committee’s opinion, cease.
- 2.40 Accordingly, the committee believes that the Minister for Health and Ageing should, as a first step, ask state and territory medical boards to review the adequacy of the National Policy for Technology Based Consultations with a view to curtailing the use of telemedicine as a first and routine method of prescribing.

The adequacy of the regulations

- 2.41 The sale of therapeutic goods in Australia is regulated, at the Commonwealth level, by the *Therapeutic Goods Act 1989* (TG Act) which provides a national framework for the regulation of therapeutic goods in Australia.⁴⁰ The TG Act makes it an offence to import, export, manufacture or supply a therapeutic good, which includes medicines and therapeutic

39 AMI, Submission No. 13, p 8.

40 Therapeutic Goods Administration (TGA) viewed on 19 October 2009 at <<http://www.tga.gov.au/docs/html/tga/tgaginfo.htm>>.

devices, unless it is included in the Australian Register of Therapeutic Goods.⁴¹ A therapeutic good is defined as:

... a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use.⁴²

- 2.42 Certain therapeutic goods can be exempted from the requirements of the TG Act and can thus be manufactured and dispensed outside the requirements of the act. In this instance the relevant exemptions allow medical practitioners to prescribe “compounded” medicines for their own patients and for pharmacists to produce the compounded medicines.⁴³
- 2.43 Compounded medicines are one off products made for an individual patient from raw ingredients which may or may not have been assessed by the Therapeutic Goods Administration (TGA) for safety and efficacy.⁴⁴ Doctors can prescribe compounded medications for patients when there is no suitable existing medicine. However, the vast majority of patients are treated with various doses of existing registered medicines.⁴⁵
- 2.44 The committee questioned the Pharmaceutical Society of Australia (PSA) about the need for and practice of compounding within pharmacies. The PSA indicated that the original purpose of compounding was to allow doctor to prescribe and pharmacists to provide treatment to a patient when no suitable alternative existed. According to the PSA, compounding:
- ... it is very much focused on the needs of an individual patient where there is not a commercially available product that is suitable for their needs. So it would be the exception rather than the rule. And it would not be first-line therapy; it would be second-line. If there is nothing available in the commercial sphere for the needs of that particular patient, the doctor may consider prescribing a compounded product, which the pharmacist would make up according to those instructions.⁴⁶
- 2.45 AMI prescribes compounded medications for its patients which are individually tailored to the unique needs of each patient.⁴⁷ While AMI strongly defends the efficacy of the individual ingredients of their

41 Maskell-Knight, C., TGA, Transcript, p 3.

42 TGA viewed on 19 October 2009 at <<http://www.tga.gov.au/docs/html/tga/tgaginfo.htm>>.

43 Maskell-Knight, C., TGA, Transcript, p 4 and 8. See also Pinski, N., RACGP, Transcript, p 8.

44 Maskell-Knight, C., TGA, Transcript, p 8.

45 Mackey, P., Pharmaceutical Society of Australia (PSA), Transcript, p 25.

46 Mackey, P., PSA, Transcript, p 27.

47 Doyle, R., AMI, Transcript, p 27. See also a number of supporting documents provided by AMI and accepted as Exhibits to the inquiry which are listed at Appendix C.

treatments,⁴⁸ a number of witnesses at the roundtable questioned whether or not AMI products were, in fact, effective at treating ED.⁴⁹

- 2.46 The committee is not in a position to make a judgement of the efficacy of AMI's compounded prescriptions - in fact no one is. The exemption from the TG Act for compounded products also exempts AMI from having to run clinical trials on the products in their compounded form.⁵⁰ Each treatment is individually formulated, and therefore there is no clinical evidence to support whether the unique combination is or is not effective.
- 2.47 The committee is concerned that consumers are not aware of the fact that the products, in their compounded form, have not been subject to clinical trials. The committee thinks that this is important information that consumers should be aware of, and urges the Federal Government to ensure that compounded medications are clearly identified as such so that consumers can make an informed choice about their treatment.
- 2.48 Irrespective of claims about the efficacy of the drugs, the fact remains that AMI is prescribing a significant number of patients with individual compounded treatments. Australian Custom Pharmaceuticals (ACP), which is the largest compounding pharmacy in Australia and the supplier of AMI medications, submitted that it has created over 15 million individually compounded treatments for AMI patients alone, and another 2,500 for other medical practitioners.⁵¹ This is despite the fact that there are clinically proven and registered drugs that are recognised as first-line drug therapies for ED.⁵²
- 2.49 The committee believes that the number of individual treatments being prescribed by AMI and manufactured by ACP verges on mass production and is not in keeping with the justification for exempting compounding from the standards required by the TG Act.

Compounding subject to review by Therapeutic Goods Administration

- 2.50 The significant growth in the practice of compounding resulted in the TGA commissioning a review of the industry which was undertaken in 2005. This review has led to the production of a discussion paper by the

48 Doyle, R., AMI, Transcript, p 54.

49 See for example: Malouf, D., USANZ, Transcript, p 18 and Lording, D., Andrology Australia, Transcript, p 20.

50 Maskell-Knight, C., TGA, Transcript, p 7.

51 Australian Custom Pharmaceuticals, Submission No. 14, p 1.

52 Malouf, D., USANZ, Transcript, p 40.

National Co-ordinating Committee on Therapeutic Goods (NCCTG) which proposed the following amendments:

... traditional low-risk extemporaneous dispensing for individual patients would continue to be self-regulated against professional standards; moderate levels of compounding would be regulated by credentialling of pharmacists and accreditation of pharmacies by a professional pharmacy body against new professional standards; and higher volume compounding and the compounding of high-risk medicines would be brought under the scope of the TGA, and people carrying out those activities would be required to hold a manufacturing licence.⁵³

- 2.51 The committee questioned AMI about its response to the recommendations of the NCCTG. AMI responded that it accepted the issue around high risk medication but rejected concerns about high volume compounding:

The real question here is whether the medications [you're] using are high-risk medications or low-risk medications. High-risk medications should be subject to a higher degree of regulation than low-risk medications. Volume I think should actually be irrelevant. You are more likely to have an error with someone who does not know what they are doing than with someone who does.⁵⁴

- 2.52 In its supplementary submission to the inquiry, AMI states that it does not support proposals to limit the number of prescriptions which a compounding pharmacy may dispense. AMI adds that changes to the regime allowing the provision of compounding and off-label treatments to patients will impede the ability of practitioners to treat them.⁵⁵

- 2.53 However, at the hearing AMI indicated that it will comply with relevant laws and regulations and it would change its business practices to comply with any possible changes to regulations.⁵⁶

- 2.54 The NCCTG discussion was open for consultation until 23 May 2008, and the NCCTG is still considering the proposal.⁵⁷

53 Maskell-Knight, C., TGA, Transcript, p 5.

54 Doyle, R., AMI, Transcript, p 28.

55 AMI, Supplementary Submission No. 13.1, p 5.

56 Doyle, R., AMI, Transcript, p 53.

57 Further information about the review can be accessed from the TGA website at <<http://www.tga.gov.au/meds/extempcomp2.htm>>.

Committee comment

- 2.55 The committee supports the need for an exemption for compounding from the TG Act for truly unique preparations when no other suitable products are on the market. However, it appears to the committee that the volume of compounded drugs prescribed by AMI goes beyond the justification for exemption. The committee believes that the NCCTG proposed recommendations are a sensible approach to strengthening the regulations around compounding, and therefore supports their development and speedy implementation.

Integration with the proposed e-health record

- 2.56 A key health reform is to reduce the fragmentation of services to patients. GPs are the primary "gatekeepers" to the health system and play a role in coordinating patient treatment. However, while a patient can receive prescriptions from more than one doctor, specialist or outpatient clinic the risk remains that no one health professional may be even aware of all the patient's treatments or total drug intake. The result may be prescriptions of contra indicated drugs as patients are placed on multiple medications by different health professionals.
- 2.57 In response, the National Health and Hospital Reform Commission is considering an electronic record system into which medical professionals enter patient records. This would allow different health professionals to access an individual's complete health record. As Dr Pinskiar explained:
- The National Health and Hospitals Reform Commission is now focusing on the concept of a patient centred record, which will contain information from all providers. We are not sure how this particular process will be incorporated into that process.⁵⁸
- 2.58 The committee is concerned that patients treated by commercial ED clinics and the doctors working in them are particularly isolated from the wider health system. The exchange of patient information to and from a patient centred record would help reduce the risks that patients are prescribed or treated inappropriately.
- 2.59 At the roundtable, Dr Malouf from the Urological society outlined the difficulty one of his peers had experienced in trying to access patient

58 Pinskiar, N., RACGP, Transcript, p 23.

treatment information from AMI in order to provide care to a shared patient. Upon questioning, Mr Doyle from AMI responded that:

If someone wants to contact the CEO of the organisation rather than trying to call a call centre operator who is obviously not qualified to deal with third parties, who might be competitors and so on, it is just a matter of someone making appropriate contact and, unfortunately, people do not do that.⁵⁹

2.60 The committee is aware that it is a relatively simple procedure to obtain patient records from other medical practitioners in the mainstream system. The committee does not think that it is sufficient to state that medical professionals should contact the CEO when requesting patient records. These records should be more easily available to practitioners who have requested them on behalf of a patient, with informed consent. This existing difficulty of professional communication further isolates AMI from the wider health system.

2.61 Given the current difficulties that doctors face in obtaining information from AMI, the committee questioned AMI about the proposed e-record system and whether or not they would freely participate. AMI indicated that it would be relatively easy to integrate their records with any proposed e-record system:

We would have absolutely no issue with that. AMI actually has a fully computerised database, which is web based. For every single person who interacts with our clinics every interaction is recorded on our patient database. For us to interact already computerised records into another computerised system is not difficult at all.⁶⁰

Committee comment

2.62 The committee encourages the Federal Government to ensure that it consults with commercial ED clinics when developing and implementing the proposed e-record system, given AMI's stated willingness to participate in the proposed reform agenda. It will be important to ensure that they and their doctors, like other medical practitioners, are included in the program.

59 Doyle, R., AMI, Transcript, p 27.

60 Doyle, R., AMI, Transcript, p 27.

Conclusion

- 2.63 The roundtable has raised issues about the way that men suffering ED are diagnosed and treated in the health system. The evidence highlighted the need to better equip GPs to manage and treat ED. Moreover, the committee was alerted to the need for the regulations covering the prescription and supply of compounded medications to be tightened and for the use of telemedicine as a routine method of prescribing to be restricted.
- 2.64 As the committee has learned, ED is often an indicator of underlying health problems. We need to make it easier for men suffering ED to turn to GPs rather than to commercial ED clinics. GPs are far better placed to identify underlying conditions while treating ED than are commercial ED clinics as they currently practice. Bringing men suffering ED into the wider health system will hopefully lead to earlier detection of any more serious conditions they have and also reduce the longer term burden to the health system.

Steve Georganas MP
Chair



Appendix A – Roundtable participants

Friday, 21 August 2009 - Canberra

Advanced Medical Institute

Mr Richard Doyle, Legal Adviser

Dr Jack Vaisman, Chief Executive Officer

Andrology Australia

Professor David Handelsman, Board Member and Adviser

Professor Douglas Lording

The Freemasons Foundation Centre for Men's Health

Professor Villis Marshall, Director

Impotence Australia

Mr Brett McCann, Chief Executive Officer

Mrs Desiree Spierings, Sex Therapist

Medicines Australia

Mr Michael Fitzsimons, Manager, Policy

Pharmaceutical Society of Australia

Mr Paul Mackey, Director, Policy

The Royal Australian College of General Practitioners

Dr Nathan Pinski, Member

The Royal Australasian College of Physicians

Associate Professor Chris McMahon, Member, Chapter of Sexual Health Medicine

SHine SA

Ms Kaisu Vartto, Chief Executive Officer

Therapeutic Goods Administration

Dr Peter Bird, Office of Non-Prescription Medicines

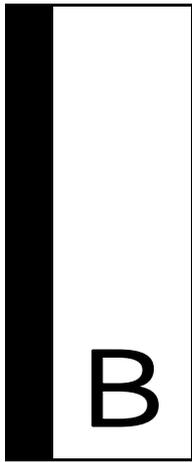
Mr Charles Maskell-Knight, Principal Adviser, Regulatory Reform

The University of Sydney

Dr Patricia Weerakoon, Coordinator of the Graduate Program in Sexual Health

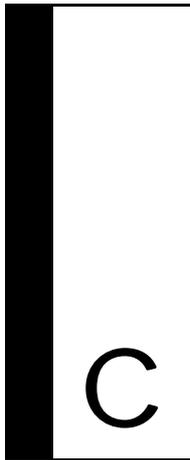
The Urological Society of Australia and New Zealand

Dr David Malouf, President



Appendix B – Submissions

1. Professional Compounding Chemists of Australia Pty Ltd
2. Australasian Compounders Association
3. Eli Lilly Australia Pty Ltd
4. University of Sydney, Faculty of Health Sciences
5. Sexual Health Australia
6. Andrology Australia
7. The Royal Australasian College of Physicians
8. The Urological Society of Australia and New Zealand
9. New South Wales Medical Board
10. Legal Aid Queensland
11. Pfizer Australia
12. Confidential
13. Advanced Medical Institute
- 13.1. Advanced Medical Institute (Supplementary to Submission No. 13)
- 13.2. Advanced Medical Institute (Supplementary to Submission No. 13)
14. Australian Custom Pharmaceuticals Pty Ltd
15. Pharmaceutical Society of Australia



Appendix C – Exhibits

- 1 National E-Health Transition Authority, *Seamless communication for the whole health sector*.
- 2 Urological Society of Aus and NZ, *Letter to AMI from client*, Related to Submission No. 8.
- 3 Urological Society of Aus and NZ, *Dr Malouf's speaking notes*, Related to Submission No. 8.
- 4 Urological Society of Aus and NZ, *Email from urologist*, Related to Submission No. 8.
- 5 NSW Medical Board, *National Policy for Technology-Based Patient Consultations*, Related to Submission No. 9.
- 6 NSW Medical Board, *Code of Professional Conduct*, Related to Submission No. 9.
- 7 Advanced Medical Institute, *AMI Booklets and CDs*, Related to Submission No. 13.
- 8 Advanced Medical Institute, *American Urological Association Guidelines on the Pharmacologic Management of Premature Ejaculation*, Related to Submission No. 13.
- 9 Advanced Medical Institute, *Andrology Australia fact sheet, Erectile Dysfunction*, Related to Submission No. 13.
- 10 Advanced Medical Institute, *Andrology Australia fact sheet, Sexual Difficulties*, Related to Submission No. 13.
- 11 Advanced Medical Institute, *Media article from Chemist and Druggist, Boots rolls out Viagra service*, Related to Submission No. 13.

- 12 Advanced Medical Institute, *The Pharmaceutical Journal*, *Boots launches private PGD service to supply Viagra*, Related to Submission No. 13.
- 13 Advanced Medical Institute, *Pathophysiology of Erectile Dysfunction*, *extract from eCMAJ*, Related to Submission No. 13.
- 14 Advanced Medical Institute, *The Cochrane Collaboration*, *Telephone consultation and triage: effects on health care use and patient satisfaction (Review)*, Related to Submission No. 13.
- 15 Advanced Medical Institute, *International Journal of Impotence Research*, *Combination therapy for Erectile Dysfunction*, Related to Submission No. 13.
- 16 Advanced Medical Institute, *Doctor Consultation Survey*, *Premature Ejaculation*, Related to Submission No. 13.
- 17 Advanced Medical Institute, *Doctor Consultation Survey*, *Erectile Dysfunction*, Related to Submission No. 13.
- 18 Advanced Medical Institute, *International Journal of Impotence Research*, *'Off-label' drug use: an FDA regulatory term, not a negative implication of its medical use*, Related to Submission No. 13.
- 19 Advanced Medical Institute, *International Journal of Impotence Research*, *'Off-label' drug use in sexual medicine treatment*, Related to Submission No. 13.
- 20 Advanced Medical Institute, *International Journal Impotence Res*, *Long term evaluation of local complications of Self Intracavernous Injections (SICI)*, Related to Submission No. 13.
- 21 Advanced Medical Institute, *Letter from NSW Medical Board*, *Proposal for examination of patients by video conferencing*, Related to Submission No. 13.
- 22 Advanced Medical Institute, *International Journal of Impotence Research*, *Nonarteritic anterior ischemic optic neuropathy with PDE-5 inhibitors for Erectile Dysfunction*, Related to Submission No. 13.
- 23 Advanced Medical Institute, *Journal of Urology*, *Intracavernous self-injection of vasoactive drugs in the treatment of impotence: 8 year experience with 615 cases*, Related to Submission No. 13.
- 24 Advanced Medical Institute, *CNN report*, *Impotence drugs may increase risk of sudden hearing loss*, Related to Submission No. 13.
- 25 Advanced Medical Institute, *NASTECH Pharmaceutical Company Inc.*, *Press Release*, Related to Submission No. 13.

- 26 Advanced Medical Institute, *Medscape (Medical News), Daily Apomorphine may be useful for women with Sexual Arousal Disorder*, Related to Submission No. 13.
- 27 Advanced Medical Institute, *International Journal of Impotence Research, Physiology of female sexual function and dysfunction*, Related to Submission No. 13.
- 28 Advanced Medical Institute, *Patient Satisfaction Testimonials*, Related to Submission No. 13.
- 29 Advanced Medical Institute, *Extract, Vectura announces positive data from clinical trial on its treatment for Erectile Dysfunction*, Related to Submission No. 13.
- 30 Advanced Medical Institute, *Extract, Comparison of Sildenafil Citrate (Viagra) versus Trimix Intracavernosal Injection (ICI) as treatment for Erectile Dysfunction (ED)*, Related to Submission No. 13.
- 31 Advanced Medical Institute, *Vectura announces successful outcome of second phase IIb clinical study on VR004*, Related to Submission No. 13.
- 32 Advanced Medical Institute, *Extract, Intracavernosal therapy: when oral agents fail*, Related to Submission No. 13.
- 33 Advanced Medical Institute, *Urology Sydney, information on Erectile Dysfunction*, Related to Submission No. 13.
- 34 Advanced Medical Institute, *Extract, Efficacy of Sildenafil Citrate (Viagra) in men with Premature Ejaculation*, Related to Submission No. 13.
- 35 Pharmaceutical Society of Australia, *Health Advice for Life*, Related to Submission No. 15.
- 36 Legal Aid Queensland, *AMI - Satisfaction and Privacy Policy*, Related to Submission No. 10.
- 37 Advanced Medical Institute, *Journal of Sexual Medication, Premature Ejaculation: Past, Present and Future Perspectives*, Related to Submission No. 13.
- 38 Advanced Medical Institute, *Extract, Researchers examine safety of Internet prescriber service providing Erectile Dysfunction medications*, Related to Submission No. 13.
- 39 Advanced Medical Institute, *Extract, Efficacy and Safety of flouxetine, sertraline & clomipramine in patients with Premature Ejaculation*, Related to Submission No. 13.

- 40 Advanced Medical Institute, *Journal of Andrology, Local Therapies to Heal the Penis: Fact or Fiction*, Related to Submission No. 13.
- 41 Advanced Medical Institute, *The Journal of Family Practice, What is the best drug for Premature Ejaculation*, Related to Submission No. 13.
- 42 Advanced Medical Institute, *Journal of Urology, Current and Future Pharmacotherapeutic Strategies in Treatment of Premature Ejaculation*, Related to Submission No. 13.
- 43 Advanced Medical Institute, *Premature Ejaculation and other Ejaculatory Disorders, Diagnosis and Management, GP Guide*, Related to Submission No. 13.
- 44 Advanced Medical Institute, *Australian Doctor, How to Treat Erectile Dysfunction*, Related to Submission No. 13.
- 45 Advanced Medical Institute, *Media Release*, Related to Submission No. 13.
- 46 Advanced Medical Institute, *International Bibliographic Information on Dietary Supplements, Return of spontaneous erection during long-term intracavernosal alprostadil treatment*, Related to Submission No. 13.
- 47 Advanced Medical Institute, *Drug Delivery Technology, Intranasal Delivery*, Related to Submission No. 13.
- 48 Advanced Medical Institute, *Drug Delivery Technology, Vortical Flow Nasal delivery's new direction*, Related to Submission No. 13.
- 49 Advanced Medical Institute, *Acta Biomedica Lovaniensia Vol 206, Development & evaluation of controlled release nasal drug delivery systems of apomorphine*, Related to Submission No. 13.
- 50 Advanced Medical Institute, *Apomorphine: The Route to successful Management of Erectile Dysfunction*, Related to Submission No. 13.
- 51 Advanced Medical Institute, *Answers.com, Apomorphine*, Related to Submission No. 13.
- 52 Advanced Medical Institute, *Current Opinion in Urology, Intracavernosal Pharmacotherapy*, Related to Submission No. 13.
- 53 Advanced Medical Institute, *Drug Delivery Technology, Nasal Delivery*, Related to Submission No. 13.
- 54 Advanced Medical Institute, *Extract, OptiNose*, Related to Submission No. 13.

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- 55 Advanced Medical Institute, *On Drug Delivery, Nasal Delivery as an Alternative to Injection: Science and Technology meet market demand*, Related to Submission No. 13.
- 56 Advanced Medical Institute, *International Society for Sexual Medicine, Standard Practice in Sexual Medicine*, Related to Submission No. 13.
- 57 Advanced Medical Institute, *Journal of Controlled Release, Nasal Drug Delivery - Possibilities, problems and solutions*, Related to Submission No. 13.
- 58 Advanced Medical Institute, *Journal of Sexual Medicine, Brain activation areas of sexual arousal with Olfactory Stimulation in men: A preliminary study using functional MRI*, Related to Submission No. 13.
- 59 Advanced Medical Institute, *Movement Disorder Society, A double-blind, placebo-controlled study of intranasal apomorphine spray as rescue agent for off-states in Parkinson's disease*, Related to Submission No. 13.
- 60 Advanced Medical Institute, *Extract, John Murtagh's General Practice Textbook*, Related to Submission No. 13.