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My Health Record

Making sure it's right, p3

INSIDE

AMA

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In this issue

My Health Record has huge potential

In order to restore public confidence in My Health Record, it is critical that privacy issues are addressed.

That was one take home message the AMA has provided the Government in its submission to the Senate Community Affairs References Committee Inquiry into the My Health Record System.

The submission noted, however, that the additional privacy protections set out in the proposed My Health Records Amendment (Strengthening Privacy) Bill 2018, go a long way towards achieving this.

This comes as a direct result of AMA President Dr Tony Bartone securing a commitment from Health Minister Greg Hunt to fix the privacy concerns.

The Bill substantially reduces any discretion that the My Health Record System Operator has to disclose health information in the My Health Record. The limits are substantially tighter than the controls that apply under the Commonwealth's Privacy Act 1988 to patient data stored in the clinician's own patient records.

The AMA would like My Health Record to succeed because the clinical benefits are considerable, and it has the capacity to save lives. But the system will need to be continually improved.

The AMA's submission notes the strengths of the system and points to potential benefits of My Health Record.

"Treating clinicians need to have access to a detailed and accurate clinical patient history to provide the best possible care," the submission states.

"The siloed nature of the Australian healthcare system and the localised storage of patient records in their doctor's own patient records, compromises the flow of patient information between healthcare settings, and between healthcare practitioners.

"Many of the greatest failures in patient care and safety result when patients are required to move across the health system, but their clinical information does not follow them.

"The My Health Record has the potential to circumvent these limitations to ensure clinically important patient information is available at the point of care, irrespective of the health care setting and the location of the treating doctor.

"The result is better connected care, reduced medical harm from avoidable medication complications and allergic reactions. As the My Health Record matures, and patient participation levels increase, the record may also generate health system efficiencies by eliminating diagnostic and pathology tests currently duplicated because test results are not available to the treating doctor.

"Not only is duplication wasteful, it is detrimental to the patient as duplicated tests expose them to additional radiation from X-rays and CT Scans."

Increased patient engagement in their own healthcare is another way the My Health Record can improve quality of care, according to the AMA.

Research indicates 40 to 80 per cent of medical information provided by healthcare practitioners is forgotten immediately by patients.

"If patients have access to their clinical data in their My Health Record, they are more likely to understand their health conditions, adhere to treatment advice and engage more actively with their treating clinicians in their ongoing care," the submission states.

"This will also assist in increasing overall patient health literacy, which will improve long-term health outcomes and indeed improve prevention and education activities."

The AMA also points out that inclusion of patient nominated advanced care planning documents in the My Health Record increases the likelihood emergency treatments will align with patient preference if they have lost the ability to speak for themselves, or have lost decision-making capacity.

"If the benefits of My Health Record are to be fully realised, the My Health Record system will need to become self-sustaining," the submission states.

CHRIS JOHNSON

The AMA's submission can be found at: https://ama.com.au/submission/ama-submission-senate-community-affairs-references-committee-inquiry-my-health-record

Making Indigenous health an election issue

BY AMA PRESIDENT DR TONY BARTONE

I recently had the honour of addressing the Australian Indigenous Doctors' Association (AIDA) Conference in Perth.

It was exciting to be in the presence of so many passionate people who are committed to achieving significant and meaningful change.

But, even in 21st century Australia, their (and our) goals and objectives face many hurdles.

Aboriginal and Torres Strait Islander people face adversity in many aspects of their lives.

There is arguably no greater indicator of disadvantage than the appalling state of Indigenous health.

Aboriginal and Torres Strait Islander people are needlessly sicker, and are dying much younger than their non-Indigenous peers.

What is even more disturbing is that many of these health problems and deaths stem from preventable causes.

There are many groups and organisations dedicated fulltime to changing things – AIDA, NACCHO, the Medical Colleges, the universities, AMSA, the nurses and midwives, and other foundations and agencies. Too many to mention, but all worthy.

The AMA places improving Indigenous health always as a major priority in our advocacy.

I see our role more as a catalyst for political action.

We have significant influence within Federal politics in Canberra across the whole spectrum of health.

We have policy, much of it contained in our annual Report Cards. And we respond to policy or funding announcements – or lack of them – at Budget time. Tragically, we have seen more cuts than top-ups. Funding is going backwards.

The core of AMA policy is proper funding for proven targeted programs and services that are delivered in a community-controlled way.

But, as we all know, the battle to gain meaningful and lasting improvements has been long and hard, and it continues.

The statistics speak for themselves:

- A life expectancy gap of around 10 years remains between Aboriginal and Torres Strait Islander people and other Australians.
- The death rate for Aboriginal and Torres Strait Islander children is still more than double the rate for non-Indigenous children.
- Preventable admissions and deaths are three times higher in ATSI people.
- Medicare expenditure is about half the needs-based requirements, and PBS expenditure is about one third the needs-based requirements.

On top of this, we have the Closing the Gap targets to map progress – or measure failure.

The latest data indicate that only three of the seven Closing the Gap targets are on track to be met.

The target to halve the gap in child mortality by 2018 is on track.

The target to have 95 per cent of all Indigenous four-year-olds enrolled in early childhood education by 2025 is on track.

The target to close the gap in school attendance by 2018 is not on track.

The target to halve the gap in reading and numeracy by 2018 is not on track.

The target to halve the gap in Year 12 attainment by 2020 is on track.

The target to halve the gap in employment by 2018 is not on track.

The target to close the gap in life expectancy by 2031 is not on track.

Three out of seven is not good.

This is a potent political message to get the attention of the major parties and the broader Australian community – the voters.

And we now have a significant opportunity to advocate strongly for Government action to do better – a Federal Election is drawing closer.

The coming months are the perfect time to campaign and advocate to improve the health of Aboriginal and Torres Strait Islander people and communities.

Everybody knows that health policy changes votes. The Coalition almost lost Government in 2016 because of health policy.

It is not surprising that we are presently seeing a much higher profile for health issues.

...continued on page 6

Conflict, 'Collaboration' (the modern euphemism for role substitution) and accountability

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

It is time for doctors to become more determined in defending the critical importance of a medical-led model of care – even if does not directly benefit them to do so. Collaboration and 'team-based' care are words used when the role of the medical practitioner is to be diminished or their leadership subverted – usually without any reduction in their responsibility or liability.

Prescription by other groups or conduct of non-medical endoscopy are good examples of these 'collaborative' models of care. Often there must be medical 'supervision' i.e. the doctor bears responsibility but is moved further away from decision-making, the conduct of a procedure or direct patient care. Clearly, this is not in the patient's best interest. Not surprisingly, there is often no evidence these models of care offer any advantage (in some cases, such as non-medical endoscopy, there is evidence to the contrary). Moreover, the diversion of more routine/simpler work deprives an increasing number of medical trainees of opportunity to gain basic skills and achieve appropriate training exposure.

The desire for pharmacists (and others) to push beyond trained scope of practice straying dangerously into medical territory is conceivably a strategy of self-defined job redefinition in order to improve market share and profit, given how aggressive the pharmacy retail market has become. The conflict that all pharmacists face when offering 'medical advice' to patients needs highlighting. When a doctor writes a script (or not) there is no change in the consultation fee. By contrast, whenever a pharmacist/retailer persuades a shopper to buy something as a result of their advice, they make more money.

The Victorian Government funding of pharmacies to provide the MMR vaccine and the truly perplexing $100 pain consultations are policies that push the patient out of GP-centred care i.e. away from the trained and experienced professional able to genuinely help. At $100 a pop for potentially ill-advised direction from a pharmacist who lacks detailed anatomy or pathology knowledge or any greater sense of medicine or what else might be wrong with a patient seems awfully expensive compared to the cost of any engaged, family GP who costs less and is able to achieve a better, holistic outcome. Contrary to what some believe, there is also absolutely no difficulty in getting access to a GP at any time. Governments who allow marginalisation of doctors/GPs to occur are therefore knowingly compromising patient care.

If doctors dispensed medications while only covering the cost of the dispensing, there would be less cost to the patient and system, and no perverse profit incentive as exists for the pharmacist. This represents the ultimate in efficiency and convenience for our patients and the healthcare system.

I can hear the usurpers citing benefits from drug companies to doctors as a prescribing incentive. This is nonsense, but let's examine it nonetheless. Non-educational benefits from industry to doctors is non-existent. My plumber can give me notepaper and a pen with company details, but a drug company cannot. It is acknowledged that all professionals are required to attend conferences that are supported by industry, there is however no evidence that this support of educational activities changes prescribing activity or causes any harm to patients. Pharmacists and nurses also attend the same conferences. Conferences in all industries (medical and non-medical) work similarly and there is no endemic problem with professionals the world over managing their decision-making adequately.

In addition, however, pharmacies receive representation and benefits from drug companies to stock certain items in their stores and promote certain products. Any retail shop owner obviously makes more money if they can persuade shoppers to purchase, for a pharmacy this might occur as a result of providing 'medical advice'. Sometimes pharmacy staff are 'tested' by mystery industry shoppers coming in with a certain problem and asking for advice. If the pharmacy staffer promotes certain products (regardless of the evidence base or lack thereof) to the customer, there can be rewards. I would imagine the pharmacist therefore to have more difficulty managing their conflicts than any doctor.

Doctor errors are given wide public coverage and Government seems bent on maintaining a very strong regulatory presence. Equally then, the pharmacists and all those who want extra responsibility, if they get it, are to be bound by the same regulatory and training standards. Let them be similarly accountable when they make a mistake. Indemnity insurance costs must go up to cover the increased risk and they will need robust continuing profession development approved by the appropriate regulatory body and so on. No short-cuts!

Collaboration is a euphemism for role substitution and we (Government included) need to stop allowing it under any guise, no matter how seductive the model looks on the surface. What

...continued on page 7

Greetings from the new Secretary-General

BY AMA SECRETARY-GENERAL DR MICHAEL SCHAPER

It's a great pleasure to take up the role as your new national Secretary-General.

The SG's role is pretty straight forward: to ensure that the machinery of the national secretariat is working efficiently and effectively, supporting our elected officebearers in their role as the national public face of the profession, and helping the different State and Territory AMAs in their work.

Advocacy and public campaigning is central to the work of the AMA, and to do this well we need to have a sophisticated team of policy personnel, media experts and administrators backing them up.

Doctors and the members of the broader medical community continue to be rated by Australians as one of – if not the – most trusted professions in the country. Medicine matters to everyone. It affects us all, and we need to ensure that Governments always keep this at the centre of their decision-making.

We will continue being active advocates for the sector. AMA members need to be getting value for money, they need to be kept informed of our policy debates and have the chance to contribute to them. We need as many doctors as possible to join, and to get involved.

The federal structure of the organisation needs to be respected and supported, so that local AMAs can also deal with local issues. We also have some great staff working in the Canberra office on your behalf, and I'm keen to attract other high-calibre recruits to join us when vacancies emerge.

Finally, we have to manage the finances of the organisation carefully, and ensure that member funds – your funds – are spent effectively. These are some of the early priorities I'll be working on.

Previous office-bearers in this position have come from a wide variety of different walks of life: while originally most Secretaries-General were doctors, over the last 30 years the reach has expanded to include lawyers, ministerial advisers, health sector administrators, and a range of others.

My own background is also similarly diverse, with experience in small business advocacy, senior government administration, politics, academia, professional associations and national regulation. (Incidentally, that's where the "Dr" title comes from – a PhD based on research into some professional practice management issues in the allied health sector.)

Finally, I hope also to be able to get out and meet as many members and local office-bearers as possible. A national organisation has its membership spread right over the country, and I'll be working with our President to ensure that we both get to meet with, and hear the concerns of, AMA cardholders across Australia.

After all, it's your organisation, and we're here to serve you.

President's message ...continued from page 4

We currently have a renewed focus on aged care. The Government has announced a Royal Commission.

The Government has announced more funding for meningococcal vaccine.

There is an ongoing review of the Medicare Benefits Schedule. Changes to private health insurance will be announced soon.

The Health Minister relishes making regular 'good news' announcements of new drugs and treatments under the Pharmaceutical Benefits Scheme – the PBS.

And there will be a bidding war on public hospital funding, just like we saw on MRI machines.

All these things cost money – lots of money. No doubt there will be more significant funding announcements across the health portfolio in the next six to nine months.

We must ensure that Indigenous health gets its fair share.

The AMA has repeatedly said that it is not credible that Australia, one of the world's wealthiest countries, cannot address the health and social justice issues that affect three per cent of its citizens.

We will continue to work with all governments and all political parties to improve health and life outcomes for Aboriginal and Torres Strait Islander people.

The AMA will make Indigenous health an election issue.

AMA lobbies for additions to Royal Commission terms

The AMA has called for a regulated registered nurse-to-resident ratio in aged care facilities, and has asked the Government to consider this while setting the terms of reference for the Royal Commission into the sector.

In its submission to the consultation for the terms of reference, the AMA said the Royal Commission into Aged Care Quality and Safety must consider such a ratio and ensure it is flexible enough to adapt to the specific needs of individual residents and aged care facilities.

The submission asks for six additional terms of reference to be added to the Royal Commission's scope. These are:

- the impact of the fragmentation of State and Commonwealth health and aged care systems on the standard of care of older people;
- access gaps to clinical care in all aged care settings, including residential facilities, the older person's home, and in the community;
- the suitability of funding models, and the level of funding, for the care of older people in the health and aged care systems;
- the suitability of the aged care workforce skills mix, and the case for a regulated registered nurse-to-resident ratio that is adequate and reflects the individual levels of care needed by older people living in residential facilities;
- quality of, and access to, specialist support and allied health in aged care settings, including palliative care, mental health care, and services such as physiotherapy, audiometry, dentistry, optometry, and occupational therapy; and
- the availability of, and need for, research and data concerning the care of older people.

AMA President Dr Tony Bartone said Australia's culture must change to ensure older Australians are respected and have necessary autonomy regarding their care.

"AMA members are deeply concerned and have repeatedly, and continuously, expressed their frustration that the health and aged care systems are not well coordinated or resourced to allow timely access to clinical care for older people," he said.

"Entering a residential aged care facility is usually not a lifestyle choice, but a necessity often due to chronic medical conditions resulting in permanent disability.

"With an ageing population, and aged care reform moving to ensure older people can stay in their home for as long as is appropriate, it is likely that the clinical attention required by those in residential facilities will become more intense.

"The Government must, as a matter of urgency, ensure that the health and aged care systems, and their workforces, are prepared for this."

Dr Bartone said there had been too many cases of elder abuse and neglect in aged care to ignore.

Many cases involve inadequate clinical care. And many aged care providers commonly do not meet the Clinical Care Accreditation Standard, likely due to a shortage of trained, experienced, and appropriate staff, and a lack of resources.

"There are not enough registered nurses with aged care experience to provide the clinical governance, oversight, and leadership required in these facilities, leading to poor clinical care, inadequate communication, and a lack of knowledge about individual residents," Dr Bartone said.

"One in three AMA members who currently visit patients in residential aged care facilities report that they are planning to scale back or completely end these visits within the next two years, largely due to the lack of access to nurses and the problems that stem from this.

"Registered nurses must be available in sufficient numbers, 24 hours a day, where appropriate, to ensure older people's clinical care needs are adequately met, and the non-nursing workforce must be better trained."

See https://ama.com.au/submission/ama-submission-department-health-terms-reference-royal-commission-aged-care-quality-and for the AMA's submission on the consultation for the Royal Commission's Terms of Reference.

CHRIS JOHNSON

Vice President's message

...continued from page 5

usurper groups manage to gain, they should be solely and proportionately responsible for – they cannot take the cream but leave the real work and responsibility to doctors given the training and experiential requirements of future generations of doctors. There is to be no more medical 'supervision' of other groups doing a doctor's job. We have a record number of doctors able to competently do medical work – there is simply no need for the type of role substitution models being peddled by usurper groups at present.

If the Guild wants to be truly collaborative, put profits aside and help embed pharmacists in general practices to perform medication reviews and support a true multi-disciplinary, doctor-led team.

More deaths from dementia

Deaths from dementia are on the rise in Australia.

Over the past decade, the number of deaths from dementia in this country has increased by 68 per cent.

Over the same period, other leading causes of death, such as ischaemic heart disease and cerebrovascular diseases like stroke and other circulatory conditions, have decreased.

In 2008, deaths from dementia were at a rate of 33.1 deaths per 100,000 people. In 2017, the rate had risen to 41.6 per 100,000.

This is according to the *Causes of Death 2017 Report* recently released by the Australian Bureau of Statistics.

The report shows:

Leading Causes of Death, Australia

Cause of death	2008	2012	2017
Ischaemic heart diseases	23,813	20,108	18,590
Dementia, including Alzheimer disease	8,172	10,367	13,729
Cerebrovascular diseases	11,979	10,785	10,186

Dementia Australia, the peak body for people living with dementia and their carers, has stressed that the updated data reinforces the need for major investment in dementia.

Chief Executive Officer Maree McCabe said the investment needed to be in research, services and support, as well as in educating the community to raise awareness about dementia.

"If this trend continues, dementia, sadly, will become the leading cause of death of all Australians in just a few years," Ms McCabe said.

"Dementia must be a health and ageing policy priority for all State and Federal Governments, health services and the aged care sector.

"With more than 436,000 Australians living with dementia and an estimated 1.45 million people involved in the care of someone with dementia, it is clearly one of the biggest public health challenges facing Australia."

Currently, dementia is Australia's second leading cause of death overall, and the leading cause of death of women.

The number of Australians living with dementia is projected to reach almost 1.1 million by 2058.

CHRIS JOHNSON

The ABS's Causes of Death 2017 Report can be found at: http://www.abs.gov.au/Causes-of-Death

AMA can't support nurse prescribing proposal

The AMA cannot support a proposal for registered nurses to be able to prescribe scheduled medicines as it currently stands, it has told the Australian Health Practitioner Regulation Agency (AHPRA).

In a submission, the AMA argues that the Nursing and Midwifery Board has not yet made a good case for the benefits of registered nurses prescribing, or the need to change current prescribing restrictions.

"Assumptions continue to be made that expanding scopes of practice is the answer to meeting unmet demand and providing cost-effective, high-quality care, despite there being little to no high-quality evidence to support these assumptions," the AMA said.

"In the majority of studies, non-medical prescribers prescribed more drugs, intensified drug doses, and used a greater variety of drugs compared to usual care medical prescribers.

"This is of particular concern considering that Australia and other developed countries are currently seeking to reduce over-prescribing, eg antibiotics and opioids."

BY MARIA HAWTHORNE

The submission can be read in full at https://ama.com.au/submission/ama-submission-registered-nurse-prescribing-proposal-september-2018

Catching up with the Councillors

This will come as news to most members of the AMA Federal Council, but *Australian Medicine* wants to publish short profiles on as many of them as are willing. These will be light and friendly, with the aim giving our readers a small insight into the personalities i.e. likes, dislikes etc of those at the helm of the organisation.

Councillors will be asked to answer a few simple questions. We start this edition with the AMA President. For the other Councillors, please keep an eye on your inbox.

AMA President Dr Tony Bartone

***AM*:** What are you reading right now?

TB: Among the many policy reviews and submissions to various committees and inquiries, I am trying to finish the second instalment of *The Girl with the Dragon Tattoo* trilogy of novels. It took me a year to finish the first one. Now I'm onto phase two.

***AM*:** What music do you like?

TB: Everything from opera and classical, right through to whatever is on the top 20 countdown. I try to keep abreast of a broad range of music.

***AM*:** Your favourite holiday destination?

TB: Tuscany, Tuscany, Tuscany... followed closely by France and Europe in general. I have it on my bucket list to visit Machu Picchu and the South Americas and I haven't been to Greece yet (can you believe that?). I want to see the Egyptian pyramids too.

***AM*:** Your favourite meal?

TB: Fish, fish and fish... breakfast lunch and dinner if I could. But I like a variety of things, except Brussel sprouts and, if I can avoid it, lamb.

***AM*:** Favourite drink?

TB: Nothing beats a nice red wine with good company, good friends and good food. Outside of that, I'm just as happy with water a lot of the time. Of course, I do love my coffee. Need my coffee.

***AM*:** What teams do you follow?

TB: Essendon Football Club in the AFL; Melbourne Storm in League; Liverpool in the Premier League; Juventus in the Serie A (Italian League); nationally, the Socceroos and Wallabies (ahh! lament); Australian test cricket; and Formula 1 on TV if I get the chance.

***AM*:** Why medicine?

TB: I have shared a lot now about the reason why I got into medicine. It was the influence of my family doctor and then me wanting to help people. I feel a deep-seated need to combine science with caring. The combination of the two works very well. For me, it was a no-brainer in the final instance.

***AM*:** Why the AMA?

TB: Having been in a variety of business environments and a variety of clinical environments, I've seen the good, the bad and the ugly of the intricacies of having to run a successful business. And then having to deal with the I intricacies of how health policy impacts on that business. The sustainability and viability of medical practices is an important reason why I got involved. But also, in terms of the wide-ranging advocacy on many health fronts, the AMA provided that natural segue for me. It scaled up as my patients got older and had to deal with more chronic illnesses. I wanted to see good policy results for their care. The AMA is right vehicle to lobby policy makers for good health policy.

AMA Twitter news

Paul Bongiorno @PaulBongiorno — Following

Why haven't Catholic or Anglican Archbishops mounted a campaign to have refugee children off Nauru? Back the AMA at least? Putting politics ahead of the Gospel.

10:13 PM - 25 Sep 2018

699 Retweets 1,945 Likes

172 699 1.9K

AMA Media @ama_media · Sep 21

Children being detained on Nauru are suffering from extreme levels of physical, emotional, psychological, and developmental distress. Urgent action is needed to help these vulnerable people #KidsOffNauru #auspol

AMA Calls On Prime Minister to Move Asylum Seek...

AMA President, Dr Tony Bartone, has written to Prime Minister Scott Morrison demanding that the Government move asylum seeker children and their families off Nauru

ama.com.au

4 110 98

Australian Gun Safety Alliance @AustGunSafety — Following

Thank you @ama_media

New gun safety alliance will save lives

The Australian Gun Safety Alliance, a coalition of concerned organisations committed to ensuring that gun laws are upheld around the nation, will save lives, AMA President, Dr Tony Bart...

ama.com.au

Lyn Morgain Retweeted

Dr Jill Tomlinson @jilltomlinson · Sep 30

I'm a doctor & Richmond resident. Since the injecting room trial started I haven't needed to resuscitate drug users on Victoria Street.

Good policies save lives, @MatthewGuyMP - not cost them.

#SpringSt @amavictoria

7 News Melbourne @7NewsMelbourne

A drug expert has warned people will die if Opposition Leader @MatthewGuyMP wins government and closes the North Richmond injecting room trial. @BrendanDonohoe7 #7News

AMA Media @ama_media · Sep 17

AMA survey shows that having sufficient numbers of registered nurses is the top priority for doctors visiting aged care facilities ama.com.au/media/aged-car... #4corners #auspol #AgedCareRC

Aged care funding boost welcome, but more needed

Today's announcement of an additional $106 million for the aged care system is a much-needed boost for a sector that has been neglected for far too long, but d...

ama.com.au

5 99 132

Katharine Murphy @murpharoo · Sep 20

Strong words from the AMA president: get the families off Nauru and let the doctors in. Exclusive in @GuardianAus theguardian.com/australia-news... #auspol @amapresident

AMA president calls for urgent transfer of refugee families from Nauru

Exclusive: Tony Bartone writes to Scott Morrison saying situation is 'a humanitarian emergency requiring urgent intervention'

theguardian.com

Kon Karapanagiotidis @Kon_K · Sep 20

This is big.

AMA president calls for urgent transfer of refugee families from Nauru

Exclusive: Tony Bartone writes to Scott Morrison saying situation is 'a humanitarian emergency requiring urgent intervention'

theguardian.com

Dr Bec Szabo @inquisitiveGyn — Follow

To all those #medtwitter peeps across the world couldn't be prouder to be an Australian doctor today. #advocacy #leadership #KidsOffNauru #DoctorsForAsylumSeekers

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Aussie medicos join humanitarian effort for Indonesia

Australian doctors are among those helping in the aftermath of the massive earthquake and tsunami that killed more than 1300 people in Indonesia.

With the death toll rising and tens of thousands of people left homeless, the Australian Government committed $5 million in humanitarian aid to help the stricken nation.

A makeshift hospital was set up and more than 50 Australian medical professionals were sent to assist.

The $5 million in aid is in addition to the initial $360,000 the Government gave the Indonesian Red Cross.

On September 28, a 7.4 magnitude earthquake struck Sulawesi, with a subsequent seven metre tsunami sweeping Palu.

Foreign Minister Marise Payne said Australia would continue to do all it can to help our close neighbour in its time of need.

But conditions are tough and the devastation rampant. Even reaching the disaster zone has been difficult.

"It's an extraordinary challenge. I've spoken before about the remoteness of the location in Sulawesi in particular," Ms Payne told the media.

"So we think we are looking forward to, as best we can, supporting our Indonesian neighbours at this time of great need."

More than 25 countries have given assistance to Indonesia after Indonesian President Joko Widodo appealed for international help.

CHRIS JOHNSON

Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTHS:

Name	Position on council	Committee meeting name	Date
Dr Sandra Hirowatari	Chair - Council of Rural Doctors	Rural Health Stakeholder Roundtable	24/08/2018
Dr Andrew Miller	Federal Councillor - Specialty Member (Dermatology)/ MPC Member	Ministerial Advisory Committee on Out of Pocket Costs	24/08/2018
Dr Andrew Miller	Federal Councillor - Specialty Member (Dermatology)/ MPC Member	Ministerial Advisory Committee on Out of Pocket Costs	19/10/2018
Dr Julian Rait	Chair Council for Private Specialist Practice	Private Health Insurance Ministerial Advisory Committee	11/9/2018
Dr Julian Rait	Chair Council for Private Specialist Practice	Private Health Insurance Ministerial Advisory Committee	4/12/2018
Dr Graham Mercer		Improved Models of Care Working Group (PHMAC)	21/08/2108
Dr Graham Mercer		Improved Models of Care Working Group (PHMAC)	9/10/2018
Dr Graham Mercer		Rehabilitation Subgroup (IMOC)	27/9/2018
Dr Choong Siew-Yong		Mental Health Subgroup (IMOC)	28/9/2018
Dr Terence Ahern	Proxy for Dr Tony Bartone (AMA President)	Labor Ageing Roundtable	14/09/2018

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON

Free teenage vaccines for meningococcal

Recent teenage deaths from meningococcal have been the catalyst for new funding towards a greater immunisation program against the disease.

The Government has launched a new free national program for 14 to 19 year-olds, and committed $52 million to the program.

More than one million teenagers will receive the free meningococcal A, C, W and Y vaccine over the next four years.

It will be added to the National Immunisation Program from April 2019 and given to students aged 14 to 16 years under a school-based program.

Adolescents aged 15 to 19 years of age, who have not already received the vaccine in school, will be able to receive the vaccine through an ongoing GP based catch-up program.

Health Minister Greg Hunt used the announcement to stress the need for immunisation in general.

"Vaccination works and is an effective and safe tool to prevent the spread of many diseases that cause hospitalisation, serious ongoing health conditions and sometimes death," he said.

"Meningococcal is a rare but very serious infection that occurs when meningococcal bacteria from the throat or nose invades the body. The consequences are devastating for individuals and their families.

"I am absolutely committed to strengthening Australia's world-class national vaccination program and urge all Australian parents to have their teenagers vaccinated."

In recent years, there has been a rise in the number of invasive meningococcal disease cases in Australia.

In 2017, there were 382 cases reported nationally, compared with 252 cases in 2016 and 182 cases in 2015.

The Minister's announcement follows a recommendation from the Pharmaceutical Benefits Advisory Committee (PBAC) to list the meningococcal A, C, W and Y vaccine for adolescents.

The Committee is independent of Government by law and in practice. By law the Federal Government cannot list a new medicine or vaccine without a positive recommendation from PBAC.

More subsidised MRI scans made available

New Medicare-subsidised MRI licences have been granted in an additional 30 locations around Australia.

More than 400,000 Australians will now be able to access lifesaving scans for cancer, stroke, heart and other medical conditions.

The Government has allocated $175 million for the rollout, with the first 10 hospitals to receive the new Medicare support being:

- Mount Druitt Hospital, New South Wales
- Sale Hospital, Victoria
- Royal Darwin Hospital, Northern Territory
- Mount Barker, South Australia
- Pindara Private Hospital, Gold Coast, Queensland
- Northern Beaches Hospital, New South Wales
- Toowoomba Hospital, Queensland
- Monash Children's Hospital, Clayton Victoria
- St John of God Midland Public and Private Hospital, Western Australia
- Kalgoorlie Health Campus, Western Australia

Health Minister Greg Hunt said each of the sites had been identified as a location of critical patient need. In many cases hospitals already have this technology, ready to provide services from November 1 this year.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

"Not only will our new Medicare support ensure patients get the most appropriate treatment and save money, it will also cut down the amount of time patients have to spend travelling to get a scan," the Minister said.

"Medicare subsidised MRIs will be accessible in these locations from 1 November 2018, subject to the sites meeting the required approvals and administrative requirements."

A competitive public application process for the location of a further 20 Medicare eligible MRIs has also been opened.

Shadow Health Minister Catherine King welcomed the new licences, but said the Government was only following Labor's move on the issue.

"After five years of abject failure when it comes to the cost of medical scans, the Liberals have finally decided to follow Labor's lead and award more Medicare-subsidised MRI licences," Ms King said.

"When Labor was last in Government, we awarded 238 MRI licences – delivering more affordable scans to hundreds of communities across the country.

"In May this year, we promised a Bill Shorten Labor government would invest an extra $80 million to deliver a further 20 licences in locations of pressing need."

Mr Hunt pointed out that earlier this year, the Government boosted Medicare support for a new MRI scan for prostate cancer checks helping 26,000 men each year. It also provided a new Medicare listing for 3D breast cancer checks, helping around 240,000 women each year.

"The Liberal National Government has also announced an additional $2 billion investment in diagnostic imaging over the next decade," he said.

"We are retaining the bulk-billing incentive and indexing targeted diagnostic imaging services including mammography, fluoroscopy, CT scans and interventional procedures.

"By contrast, Labor has only committed $80 million and not made any commitment to the re-indexation of diagnostic imaging rebates."

An MRI is a commonly used medical scan which gives a detailed view of the soft tissues of the body such as muscles, ligaments, brain tissue, discs and blood vessels, and helps with the diagnosis of (among other things) cancer, cardiac conditions, trauma and sporting injuries.

Tenders for new aged care navigators

The Government is calling for tenders for trials of a new aged care navigator network, including information hubs, community hubs and one-on-one support from specialist workers, to streamline and simplify aged care service access.

Aged Care Minister Ken Wyatt has opened tenders for the trials, saying more help will soon be at hand for senior Australians needing guidance to navigate their way through the aged care system, thanks to the new project.

"These trials will aim to assist senior Australians and their families to get the best outcomes from the aged care system," said Minister said.

"I have been listening to people and these changes were formed following direct feedback from the community.

"Some people find it more difficult than others to navigate their way through and may need additional support to understand, choose and access aged care services.

"We want to find the best ways to break down the barriers that are preventing people from making informed choices around their aged care."

A variety of programs will be tested to help people better engage with the aged care system, including connecting them with My Aged Care and providing support to choose and access services.

Under the trials:

- 30 aged care information hubs will provide locally targeted information and build people's understanding and engagement with the aged care system;
- 20 community hubs will enable people to support each other in navigating aged care and healthy ageing; and
- Six full-time equivalent specialists in consumer-focused organisations will offer one-on-one support for vulnerable people.

The trials will aim to be of particular assistance to people who have complex needs, including those facing language and technology barriers, significant financial disadvantage or social isolation.

The trials are expected to start in January 2019 and end in June 2020.

The tender documents can be downloaded at https://www.tenders.gov.au/ from the AusTender website.

Tenders must be lodged before 2pm AEDT on Tuesday October 23, 2018.

Paying for performance

BY **PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR,** PUBLIC HEALTH, UNIVERSITY OF SYDNEY

Assessing the quality of care in general practice can mislead if it is not based on observations of that care. Asking doctors what they have done and judging quality on the basis of medical records is not good enough.

The perils of judging what happens in the clinical setting on the basis of what doctors record is obvious in a study of a health care funding agency, in this case the NHS, ceasing to pay doctors for providing additional services it regarded as so desirable that for which it had previously provided incentive payments.

A paper in the September 5 issue of the *New England Journal of Medicine* by five authors from the National Institute for Health and Care Excellence in the UK [N Engl J Med 2018; 379:948-957 or www.nejm.org/doi/full/10.1056/NEJMsa180149] used electronic medical records from 2010 to 2017 in UK general practices to assess the effects of removing, in 2014, 12 incentives linked to 12 indicators and compared the outcomes for six indicators where the incentives were maintained.

The study was set in 2,819 English general practices with more than 20 million registered patients. There were big drops – 62 per cent – in records of indicators 'related to lifestyle counselling for patients with hypertension' when the incentives were withdrawn.

The authors noted that reductions in the documentation of clinical processes varied widely among conditions – from a 6 per cent reduction for smoking counselling to a 30 per cent decrease in documenting BMI of 30 per cent among patients with mental illnesses.

The authors observe: "Several studies show that what is gained on incentive introduction is essentially lost on incentive withdrawal."

But – and here's the rub – what was gained? The authors note: "The uncertainty about whether changes in the *documentation* [my italics] of care represent true changes in patient care."

We do not know to what extent the reduced documentation of the incentivised clinical behaviours reflected reduced clinical care.

Other than the automatically updated markers (like lab tests) in the records, frequencies of other interventions were measured purely on their action being documented.

It is quite possible that the desired actions were still taking place at a similar rate, but were simply not documented. Ask any busy clinician about how record keeping can diminish when the day is long or when there's an emergency. It is hardly surprising that documentary markers decrease after removal of incentive.

An example of the disconnect between the record and the action given in the paper is that of prescription of long-term contraceptives. Although the records suggested a fall in prescriptions after the withdrawal of the incentive, actual use assessed from other sources increased.

I hold to the view, based on long observation, including a five-year stint chairing a district health board in Sydney, that our health system would grind to a halt were it not for the altruism of health professionals, including doctors. Yes, getting the right mechanism for paying for health care matters intensely, and doctors are well paid, but creating the conditions where doctors can express and apply more altruism in the system may offer the best yield in clinical care. Worth an experiment, anyway.

Recently I read *Out of the Wreckage: A New Politics for an Age of Crisis* by British journalist George Monbiot. It is an exciting and optimistic book despite the prevailing uncertainties in many democracies.

A major thesis is that the distinctive human attribute which has led humanity to its current zenith, and which Monbiot considers to be critical to our approach to the future, is altruism – by which he means people looking out for others and caring for them. You can assess the strength of his argument for yourself or watch him on YouTube www.youtube.com/watch?v=uE63Y7srr_Y

If you consider that more needs to be done in improving health care, proceed cautiously with the idea of incentive payments.

Do not be beguiled in assessing their effectiveness by the documentation of process. Rather, measure their effects on actual care and outcomes. And when considering what doctors and other health professionals do day by day and how this might be strengthened, remember that altruism – doing caring things without concern about reward – still ranks highly on the scale of what motivates them. This is why they do what they do. Make it easier for them.

Invest in quality improvement: Have doctors got the PIPs?

BY DR RICHARD KIDD, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

> "The AMA has delivered a blunt message to the Health Minister – the AMA's support for this initiative is in peril unless the PIP receives a significant boost in funding."

While having tried to play a constructive role to date, growing concerns at level of funding that will be available for the Practice Incentives Program (PIP) Quality Improvement Incentive (QII) has seen the AMA Federal Council decide that the AMA cannot support the current cost neutral approach to the introduction of the incentive.

The AMA has delivered a blunt message to the Health Minister – the AMA's support for this initiative is in peril unless the PIP receives a significant boost in funding.

While the AMA has backed the concept of an incentive to support practices in their quality improvement journey, we have consistently opposed the idea that some practices could finish up worse off. Instead of properly funding the new incentive, the Government has decided to rob Peter to pay Paul. Worthy incentives will be lost including the quality prescribing, cervical screening, asthma, diabetes and the Aged Care Access Incentive (ACAI).

The value of the ACAI must be considered in more than just monetary terms. The results of the recent AMA Aged Care Survey indicated that more than a third of doctors currently providing services to residential aged care facilities (RACFs) would either cut back or cease their visits over the next two years. I don't think it is a stretch to suggest that the impending loss of the ACAI is a contributing factor.

For general practices struggling to remain viable in the face of seemingly unending cuts and the lingering impact of the MBS freeze, PIP is a vital funding source for general practices. The AMA estimates that an injection of about $44million per annum to the PIP is required to support a meaningful PIP QII so it can deliver on its objectives.

The AMA wants to see practices embrace the QII because it has potential to improve current funding arrangements by recognising the value of quality improvement. Value for the health system, value for the practitioners, value for the patient, and value to the population through better outcomes.

Our data is the key driver to meaningful quality improvement activities. We must collect it, understand what it tells us, and use it to inform our decisions about the quality initiatives that would most benefit our patients. Data-driven quality improvement is the second building block in the Bodenheimer's 10 building blocks of high-performing primary care. By focusing on this area, we can strengthen the delivery of care to our patients and demonstrate the value of general practice in the health care system.

Good policy requires real foresight and, in cases like this, real investment. Continuing to short change the most cost-effective part of the health system will inevitably lead to downstream costs to the health system. The PIP QII is a good idea, but it is being poorly executed by a Government and Department that needs to stop paying lip-service to the importance of general practice and put their money where their mouth is.

Conscientious objections in the rural setting

BY DR SANDRA HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

What do you do when a patient or colleague asks you to do something that goes against your beliefs and principles?

It depends on the request and the strength of your conviction. A common example is termination of pregnancies – not a problem if you are all for it, quite a conundrum if you object on moral or religious grounds and cannot see yourself ever performing an abortion or even referring on to a colleague who does.

This would be a lose-lose situation – damned if you do, damned if you don't. It is important to remember that you have rights and so does the patient. But will your rights or the patient's rights be stepped on? The ideal outcome is that both the needs of the patient and the doctor are met.

In the urban setting, alternatives are available. You can make a direct or indirect referral. There are specialists in the Yellow Pages, and sexual health centres take calls, so indirectly you could respectfully refer the patient to do her own research. You could refer her to another GP colleague down the hall who does not have the same objection. This process keeps you one step removed from the act you conscientiously object to. Or, if you are comfortable, you can make a direct referral. This second type of referral takes you closer to the final termination. However you do this, your patient receives the care they need and you have not performed any actions contrary to your beliefs.

In the rural settings our options are not as broad. Often, we are the only medical resource; the timing of the pre-procedural investigations depend on us. We may need to sign the Patient Assisted Travel form that will ultimately lead to a medical act that we morally object to. We need to do the research to find the nearest provider. If you refuse, the patient meets hardship, and may have to travel far away to meet with another GP who may also have the same conscientious objection. Time is of the essence. They are bewildered and stressed and so are you.

Can you be forced?

The Medical Board of Australia states we must not impede. Your actions cannot prevent the patient from getting the care she wishes. Our Association, the AMA, states that we need to inform the patient she can receive care elsewhere. Both organisations advocate transparency so that the patients and impacted doctors are aware of our stance.

Minor examples exist, such as a doctor who does not prescribe oral contraceptive pills, or doctors who refuse to do pap smears. This objection is not just preference or distaste, it is a deep seated religious or moral objection. In the city it is no big deal, alternative care is easily found elsewhere. Rurally, it is a big deal for a patient to have to travel to receive such routine medical care.

Another example, medically assisted dying, is just around the corner. When the legislation passes, of course you cannot be forced into action. However, what happens if you are the only doctor in a rural setting, and you DO believe in assisted euthanasia? The unintended consequence of your beliefs may cause your patients to feel uneasy and as such they may wish to get their care elsewhere. Unfortunately for many patients in rural and remote regions of Australia, there is often not much choice of doctors. This scenario has been already occurring in Canada.

Rural doctor, you know your own moral beliefs, you also know whether they deviate from the majority belief.

So arm yourself.

Find a pathway that will enshrine your needs while ensuring that rural patients receive the appropriate care. Prepare a phone list of known doctors you respect, who may or may not do as the patient wishes; find doctors who will help you keep your distance from the resulting consultation; offer telephone or telehealth consultations. The best thing you can do is get support before you need help with these difficult moral and ethical decisions.

Be better prepared to respond to disclosures of intimate partner violence

BY VICTORIA COOK, VICE PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

> "Students must be taught to recognise intimate partner violence, assess risk, document disclosures, record evidence and understand legal implications."

This year, like the ones before it, Australia has been shocked by stories of horrific violence against women reported in the media. Yet for every story that is reported, many go unmentioned. Women die by violence in Australia at a rate of more than one per week. The organisation Destroy the Joint which 'counts dead women' holds this year's total at 47 women killed in Australia by September 14. There are another 13 weeks left in 2018, meaning we can expect that at least 13 more Australian women will be killed by the end of this year alone.

We know that healthcare professionals are often first responders in disclosures of domestic violence. Health professionals are the second most commonly sought source of support for women experiencing domestic violence, after family and friends. Of women experiencing domestic violence, 30 per cent will seek advice from a general practitioner and 20 per cent from another health professional. On average, eight women are hospitalised each day due to intimate partner violence, and the rate is rising. The person that a woman reaches out to, to disclose violence at home, will likely be one of us. Yet, medical students don't feel as if medical school adequately prepares them to respond to disclosures of intimate partner violence.

Medical student representatives across Australia recently unanimously endorsed a position calling for improved access to education and training around intimate partner violence. In 2015, a study showed that the median time spent on intimate partner violence in Australian medical schools, across all years of the curriculum, was only two hours[1]. One can only assume that access to education in this area after medical school is less again. Intimate partner violence is the greatest contributor to mortality and morbidity among women aged 18 to 44 in Australia. It outranks smoking, illicit drugs, and obesity. Yet the burden of illness is not reflected in the time dedicated in medical curricula or training.

Intimate partner violence is a complex and distressing topic, making it hard to teach but even more difficult for professionals to respond to without adequate training. Students must be taught to recognise intimate partner violence, assess risk, document disclosures, record evidence and understand legal implications. Medical practitioners are under-prepared to respond appropriately, which risks reinforcing women's feelings of powerlessness and violation. This is a whole society issue, and action is needed not only from medical schools, but from medical training colleges, health services, Governments (Federal, State and Territory), and individual practitioners and students. When a woman reaches out she must find someone who is equipped to help. As future doctors we know we will be faced with disclosures, and when we are, we want to be prepared.

In the wake of the tragic death of Eurydice Dixon, students and young women reckoned with an awful paradox; despite entreaties to be safe and stay home, they often aren't safer at home at all. One medical student told me she began university in Melbourne when Jill Meagher was murdered, and is graduating as Eurydice Dixon was killed. These seemingly random acts of violence remind us to fear what we do not know, whilst distracting us from the facts we do; most women who die by violence will be killed by a man that they know. Our medical education must prepare us to help prevent that.

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Night shift, naps and naysayers – not all hours are created equal

BY DR TESSA KENNEDY, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

> "There is increasing pressure to provide the same healthcare staffing and services 24 hours a day, seven days a week, in a bid to reduce hospital mortality associated with afterhours admission."

Night shift. It's 4am, and the ward is finally quiet after a rush of clinical reviews. The lights are dim, patients are all in bed, the tea room chairs converted to makeshift stretchers for nurses napping on break. I sit staring bleary-eyed at the computer screen, raising my eyebrows to keep my lids from drooping shut. There's nowhere to sleep, and if I do steal away to a couch in the office my absence will be noted. The head of department made it clear: you don't get paid to sleep. Intermittently I startle as I nod off. This matters little sitting still at a desk – it matters a lot on the drive home, as sleep presses heavy on my arms, loosening my grip on the wheel.

There is increasing pressure to provide the same healthcare staffing and services 24 hours a day, seven days a week, in a bid to reduce hospital mortality associated with afterhours admission. This, combined with efforts to reduce unpredictable and onerous working hours associated with on-call arrangements means an increase in continuous cover provided by shiftworkers.

The dual aims of improving patient access to quality care and safer working hours for doctors are noble, but the changes made to practice in order to achieve them often create new problems by neglecting to acknowledge that not all hours are created equal, and should not be treated as such.

Working at night is fundamentally different to working during the day – two very different shifts can run '8 til 8'. It is clear to anyone who has worked night shifts or indeed parented a newborn that tasks completed in the middle of the night require much more effort and are much more prone to error than those performed in the middle of the day, as sleep deprivation and disrupted circadian rhythms conspire against our best efforts.

If we treat night shifts like just another day at the office, we place patients and practitioners alike at risk of harm.

Yet interns spend more time in orientation learning which bins take which kind of waste or how to operate a fire extinguisher than how to manage the challenges and risks inherent to shift work. How to best make use of sleep, caffeine and other strategies to perform the best they can at work, and make it safely home afterwards.

We think twice before waking the on-call team, but not for denying the night shift worker the cultural permission and facilities to sleep, trusting them to know when it's the most appropriate use of their time.

Sadly, sleeping quarters traditionally utilised by doctors on call are getting absorbed by administrators who fail to realise that yes, I might be rostered 'to work', but I'm not a factory line worker for whom down time equates directly to reduced service. My job is far more complex, my cognitive powers my most important tool, and actually a nap in the 4am lull may provide the best chance of a successful resuscitation at 6am by offering more sound judgement and a steadier hand.

I'm in no way advocating for doctors who staff the wards overnight to sleep through everything but a Code Blue, but I am advocating for us to acknowledge the limits and mitigate the risks of humans operating in a high-risk field. Naps are not luxury or laziness, but akin to ensuring the defib is plugged in and fully charged so it's ready to go. Ironically, sometimes the most productive thing a night shift worker can do is nothing.

We mustn't move blindly towards a 24/7 model of healthcare without recognising and mitigating the associated risks for patient and practitioner, without taking care to decide which services are truly necessary to provide at any time, and which can be left til morning.

My Health Record important, but let's fix the problems

BY ASSOCIATE PROFESSOR ANDREW C MILLER, CHAIR, AMA MEDICAL PRACTICE COMMITTEE

> "Many of the greatest failures in patient care and safety result when patients are required to move across the health system but their clinical information does not follow them."

The policy problems the My Health Record seeks to address are genuine. The Australian health system operates as a collection of disconnected siloes. Patient records exist as isolated fractions scattered among their treating doctors. Without the MHR there is no other institutional mechanism that facilitates the flow of patient information between healthcare settings, and between healthcare practitioners.

Many of the greatest failures in patient care and safety result when patients are required to move across the health system but their clinical information does not follow them.

At the recent Senate Community Affairs Inquiry into the My Health Record System, the Chair of the AMA's Ethics and Medico-Legal Committee, Dr Chris Moy, used the following case study to illustrate the practical benefits generated by a My Health Record. The story was provided to Dr Moy by a colleague and an AMA member, Dr Danny Byrne. He wrote:

"Earlier this year I had a new patient move to Adelaide from Nepean Blue Mountains in NSW, one of the opt out trial areas.

He had a serious neurological condition and could no longer look after himself, so he had to move to Adelaide to be looked after by his brother.

Normally a new patient like this would arrive with little or no information. I would have to write to his GP and specialists in NSW for copies of his clinical records.

Invariably I would expect to receive little or no information. After weeks of waiting I would usually then start from scratch by repeating the patient's tests and starting another merry-go-round of specialist referrals. This would be at huge cost of time and money in duplication of tests and specialist referrals already done in NSW.

However, in this case the patient had a MyHR. It was immediately able to see his NSW hospital letters and results of his investigations. Within minutes I was able to pick up the required treatment plan for him recommended by his NSW specialists and begin implementing it from day one in Adelaide. This was something I had never experienced before.

The savings in time, stress and money were enormous – for the patient, his family and the wider health system.

It is ironic that I received better information from a NSW hospital that uses MyHR than I get from my local hospital a few kilometres away from me that does not.

I can see clearly now how much better care can be for patients in an opt out world for MyHR."

Despite general agreement on the need for an electronic health record, the debate about My Health Record data security and patient privacy reached fever pitch following the Minister's announcement of the start of the three-month opt out period.

The hyperbolic nature of the media debate means that it is not easy to decipher between discussion of genuine flaws in the security and privacy of the My Health Record System, and ill-informed alarmism.

What we know

The My Health Record System has multiple layers of security. Software cannot connect to the My Health Record unless it is secure, encrypted and certified as conformant. All connected software is subject to automated checks to ensure it maintains

conformity standards. To access the My Health Record System through a clinical information system a health practitioner must:

1. Install conformant clinical software;
2. Apply for a NASH PKI certificate for healthcare provider organisations;
3. Install the NASH PKI; and then
4. Access the system using local log on details.

Conformant clinical software assigns unique staff member identification codes. A log is automatically generated to record each time a patient's My Health Record is accessed by a health provider organisation. It is unlawful to access a My Health Record unless it is for the purpose of providing treatment to a patient who is a registered patient in the healthcare practice. Unlawful access to a patient's record is subject to criminal and civil penalties.

The privacy controls available to patients add further security to patient data. Patients can instruct their health provider at the point of care not to upload information they consider sensitive. They can put a Record Access Code across their whole record or an individual document so only the providers who have been given the pin code can see them. Patients can also set up alerts to receive a text or email notification if their Record is accessed by a new health provider. Patients can also remove documents from their record.

This represents a logged communication chain that far surpasses the existing standard in the vast majority of institutions and practices.

Proposed amendments

At the President's press club address in on July 25, he told journalists he would "do what-ever it takes" to prevent the rich data base of sensitive patient information in the My Health Record System being used by Governments for purposes unrelated to healthcare. The Minister responded quickly to these concerns and introduced a new bill – the *My Health Records Amendment (Strengthening Privacy) Bill 2018* (the Bill).

The amendments in the Bill provide protection to data stored in the My Health Record data base that is substantially tighter than the controls that apply under the Privacy Act 1988 (Commonwealth) to patient data stored in the clinicians own patient records. If the Bill passes the Parliament, the system operator will be prohibited from releasing My Health Record information without a court/tribunal order and only for very limited purposes.

Australians who opt out will have their MHR extinguished; as will also happen when they die. There will be no centrally collated echo to prompt privacy concerns.

Fit for purpose?

If the Bill passes Parliament and authorised disclosure concerns are addressed, will the My Health Record then be fit for purpose and acceptable to doctors? Depends who you ask. If you ask a Specialist, the answer is likely 'no'.

Many Specialists remain deterred from connecting to the My Health Record because their clinical software providers have not invested in the upgrades necessary to provide seamless interoperability with the My Health Record System. Most specialist software does not provide the option to upload Specialist letters, despite this being the most important function for Specialists' communication. It is time for Government intervention to remove this barrier to Specialist participation.

Specialists have not received anywhere near the same level of support to adopt the My Health Record as that provided to general practitioners over a number of years to date. It is vital this Government does not repeat the mistakes of the United Kingdom where they realised too late they had failed to provide sufficient technical support to clinicians who had trouble using the e-health records. Apart from the problematic interoperability between Specialist software and the My Health Record System, the compliance obligations on and doctors are substantial. Much more needs to be done to help specialists engage with the My Health Record if it is to succeed.

Furniture fashion misadventures meet managerial disrespect

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF PUBLIC HOSPITAL DOCTORS

Even a casual observer of decisions affecting human resources over time will have seen highly recommended, expert-panel derived trends come and go. But not before having been proven to have been useless, or worse, damaging to the workplace performance, trust and cohesiveness it sought to improve.

To name some recent managerial fashions: 'contracting out' (code for losing control over core aspects of the organisation and losing good people); 'performance measures that encourage internal employee versus employee competition' (thus emphasising self-interest and mistrust instead of jointly advancing organisation goals, and entirely stifling cooperation); and developing a 'culture that cares' (as we quickly learn to distrust any organisation that tells us 'we care about our people' when this is intrinsically not the case).

We are now confronting yet another one of these managerial fashion misadventures in public hospitals through attempts to rob Staff Specialists of their office space in favour of open-plan or 'hot desking' or 'hoteling' office arrangements. It may be fair to say that hospitals can struggle to accommodate their patients and their staff; limitations on space and capital for spend do exist. But this fashion faux pas agenda is actually not to create patient or even patient-care space. The agenda is instead about acting on the completely wrong beliefs that clinician offices are somehow elitist or don't serve a genuine purpose. How wrong on both counts! This fashion sense is far worse than anything I ever wore in the 1970s.

I must first focus on the mental health and general workplace wellbeing of my colleagues. An open-plan arrangement creates a lack of personal space, little-to-no privacy, constant noise and movement distraction, excessive transparency, and prevents a way of avoiding interactions that we require. Consider the 'hard' conversations that have to be had with a patient due to receive life-altering news they are not expecting, while the occupant of the next desk is on the phones to obtain agency staff for the night nursing shift. Consider the 'hard' conversations with an enthusiastic trainee who is not going to meet the required standard. Given our workload and responsibilities, basically, our cognitive and emotional resources become depleted if we don't have an office to call our own.

Hot desking/office hoteling prohibits creation of a personalised space (which is naturally comforting) and given that on any particular visit or shift you could be seated anywhere in the building, establishing valuable close relationships with nearby colleagues becomes impossible because a consistent opportunity to build rapport is undermined. How does fragmentation of collegiate relationships, insecurity arising from not having personal space and their negative impact on doctors' health and wellbeing optimise clinical outcomes for our patients?

Surely achievement of improved clinical outcomes would have to be the main aim of the whole open-plan idea, wouldn't it? I include our key training and mentoring role as a clinical improvement goal. Substantial research shows that where there are open-plan arrangements, the low levels of privacy lead to defensive behaviours and strained workplace relationships. However, fashion sense doesn't tend to worry about evidence; the open-plan leads to exactly the opposite to the clinically desirable trust-based, quality-focused supervisory and collegiate relationship.

If the idea is about efficiency, gaining 'value for money' by 'productive use of space', the imposed inefficiencies and reduced productivity arising from open-plan (due to increases in interruptions, reduced activity and productivity, and increased health-related absences, according to relevant research) makes the idea pointless. If the idea is about encouraging collaboration, some studies show that people in open-plan spaces, knowing that they may be overheard or interrupted, or are disturbing others, have shorter and more-superficial discussions than they otherwise would; hardly optimum in a clinical setting.

If the idea is about 'doctors aren't special so shouldn't have offices', no one is arguing we are special. The obviously accurate proposition is that a 'one-size-fits-all' approach does not work for all roles within a hospital. As Specialists, we have mentoring, supervision and peer review responsibilities, mountains of administrative work, clinical privacy considerations, and a need to think deeply about clinical complexity. These require private space.

Hospital productivity, collaboration goals and most importantly good patient outcomes come through doctors feeling good about their environment and through knowing they are valued and respected by their hospital. To make my point in general terms, 'productive' and 'value' are rarely well-defined but often that for which one strives. By default, these terms just become

a euphemism for 'being seen to do heaps of things'. This 'being seen to do' becomes crucial in open-plans, as it is the 'common sense' way to convince those around you (and possibly even yourself) that you're doing your job well. Instead, and in fact, this perversely rewards quantity over quality and encourages even more hours spent in the workplace over fatigue management.

Your CPHD recommends strong pushback to any move toward open-plan or other non-office-based 'inspired' accommodation for Staff Specialists. One way is to engage in a contest via the Consultation Clause contained in your State/ Territory – AMA/ ASMOF Enterprise Bargaining Agreement. I am most familiar with the new *AMA Victorian Medical Specialist Agreement 2018-2021*, which clearly defines such a move as being a 'major change' that would have a 'significant effect' on Specialists.

This activates structured procedures to guarantee the voice of Specialists and prohibits the implementations of decisions without contest about the validity of evidence. It can be a really noisy contest. Also, I point out, that any hospital slip-up in compliance with the quite prescriptive consultation obligations is in breach of the Agreement, and thus capable of being tested in the Fair Work Commission (this observation/invitation might by itself cause a hospital rethink).

Remember, this, like any fashion, once in place, may be hard to displace because the architecture/floor plan would fundamentally change. Make sure you report any move in this direction to AMA ASMOF and organise to prevent what would represent a high degree of disrespect to the profession. Your CPHD will definitely be keeping an eye on this key matter.

Research

BY CHRIS JOHNSON AND MEREDITH HORNE

Study suggests ways to cut bowel cancer numbers

Healthier lifestyles could reduce the incidence of bowel cancer in Australia by 45,000 over the next decade.

Newly published research that pooled data from seven cohort Australian studies, involving almost 370,000 people aged 18 and over, has found that a large portion of bowel cancers are preventable through the adoption better lifestyle choice.

The study by researchers from UNSW's Centre for Big Data Research in Health has found that current rates of smoking, obesity and excessive alcohol consumption could lead to 45,000 cases of bowel cancer over the next 10 years.

The results, first published in *JNCI Cancer Spectrum*, have implications for public health education, promotion and policy.

UNSW Associate Professor Claire Vajdic said the researchers examined the factors causally associated with developing bowel cancer and their current distribution in the Australian population.

They found that 11 per cent of the future bowel cancer burden can be attributed to ever-smoking, and four per cent to current smoking.

Overweight or obesity was responsible for 11 per cent of cases, and excessive alcohol consumption contributed six per cent of the burden.

"We then explored what this means for the future bowel cancer burden in Australia, and where we should be targeting our health promotion efforts," Prof Vajdic said.

"Combined, these factors will be responsible for one in four future bowel cancers – even more so for men – 37 per cent of bowel cancers – than women – 13 per cent.

"If people changed their behaviours accordingly, a large proportion of this future burden could be avoided."

The study is the first to identify subgroups within the population with the highest burden.

The patterns were due to differences in both the prevalence of these lifestyles – both factors are more common in men – and the strength of the association between the lifestyle factors and bowel cancer risk.

"We found that more bowel cancers were caused by overweight or obesity and excessive alcohol consumption in men than in women," Prof Vajdic said.

"Hormones and differences in body fat distribution, particularly excessive fat around the stomach, likely contribute to the higher body fatness-related risk in men. We also know that men drink more alcohol than women, which increases their bowel cancer risk."

The researchers also found an interesting interplay between smoking and alcohol: the bowel cancer burden attributable to smoking was significantly exacerbated by excessive alcohol consumption, and vice-versa.

This means that the future bowel cancer burden would be markedly lower if current and former smokers did not drink excessive alcohol. The study results have important public health implications.

The findings can inform both general and targeted education, public policy, health literacy and health promotion campaigns aimed at reducing cancer incidence and maximising early detection.

Prof Vajdic said the results suggest education efforts may need to be especially directed towards current and former smokers, given their increased burden.

The results can also be translated into a number of health recommendations.

"We know that smokers are less likely to participate in our National Bowel Cancer Screening Program, so they are a particularly vulnerable group," she said.

"Our findings make a case to support everybody – but men in particular – to achieve and maintain a healthy weight to prevent bowel cancer."

The current Australian recommendations for healthy living are to not smoke, to do at least 150 minutes of moderate or 75 minutes of vigorous physical exercise per week, to maintain a healthy weight (BMI 18.5 - 25 kg/m2), to drink fewer than two alcoholic drinks per day, to not eat more than 65 grams of red meat per day, and to keep processed meat consumption to a minimum.

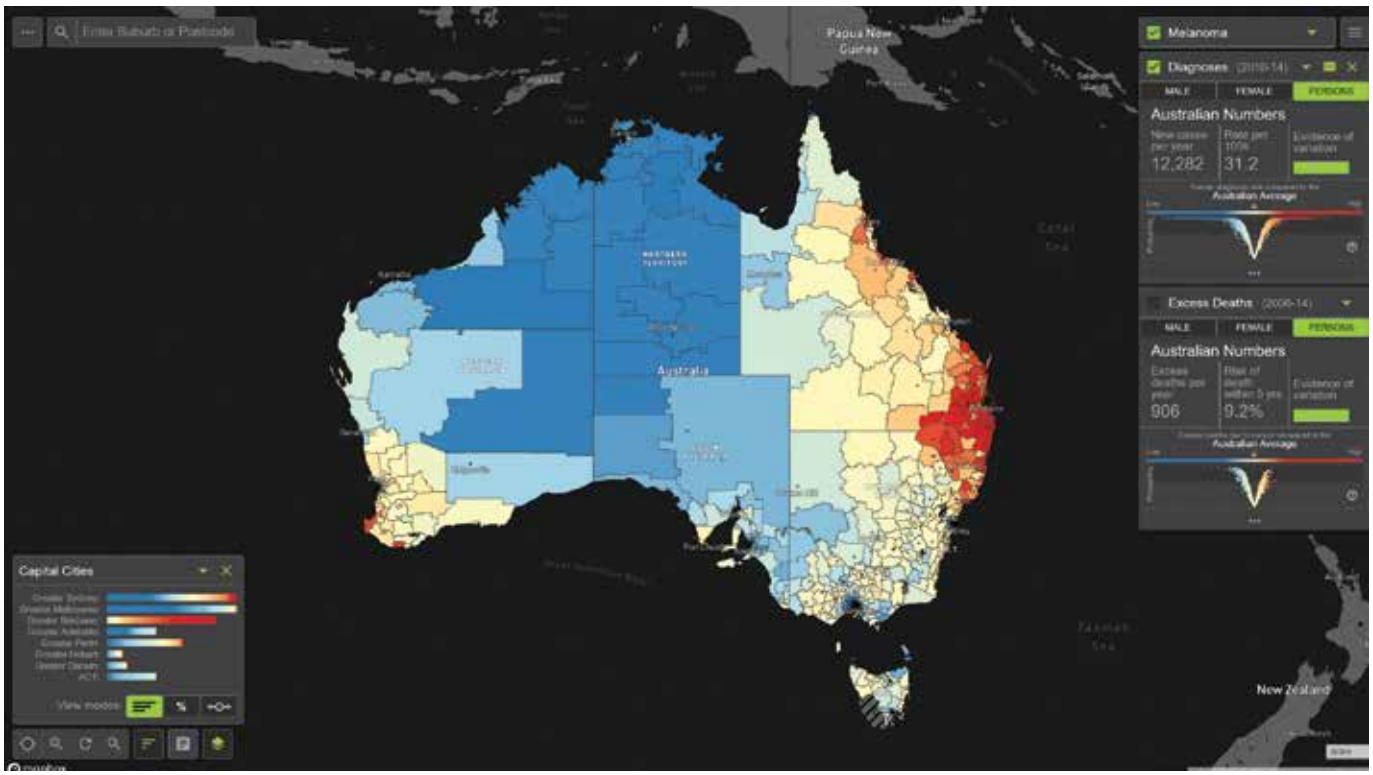
Research collaborator and Cancer Voices South Australia representative, Julie Marker, has survived bowel cancer three times over the past 17 years.

"Any action you can take to prevent or detect bowel cancer early might save you from the battle I've had," she says.

"I'd encourage men and women – but especially men – to adopt a healthy lifestyle and participate in bowel cancer screening to reduce their risk. GPs and other health professionals should target prevention and screening advice to their patients, using insights from this research."

Research

Cutting-edge cancer map for Australia



A new interactive online tool reveals in a few clicks cancer patterns nationally and at the local level.

The recently launched Australian Cancer Atlas, allows Australians to discover the impact of cancer in their suburb or town.

It is an interactive, colour-coded, digital cancer atlas showing national patterns in cancer incidence and survival rates based on where people live.

It holds data for 20 of the most common cancers in Australia, such as lung, breast and bowel cancer, and the likely reflecting the characteristics, lifestyles and access to health services in each area.

The project, led by researchers from Cancer Council Queensland, Queensland University of Technology (QUT) and FrontierSI, gives health agencies and policy makers a better understanding of geographic disparities and health requirements across the country.

Cancer Council Queensland Head of Research, Professor Joanne Aitken, said the digital atlas highlighted which geographical areas had cancer rates below or above the national average.

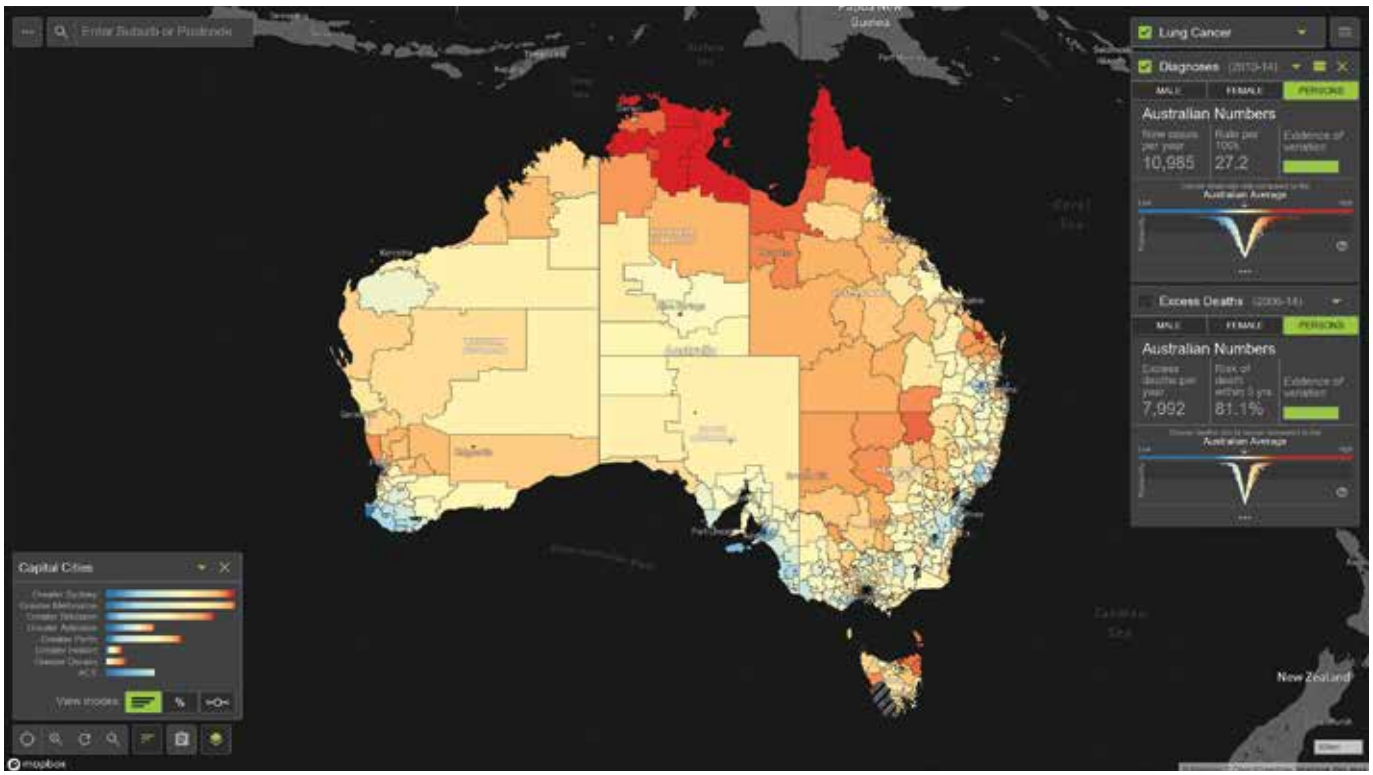
"Australians can filter down to look at the impact of various types of cancer in the region where they live, to understand cancer patterns across the country. However, it's important to remember that local cancer trends won't necessarily reflect your own cancer risk," Prof Aitken said.

"Cancer rates vary across geographic regions depending on things like the age of local residents, participation in screening programs and trends in terms of cancer risk behaviours.

"One of the most revealing patterns in the atlas was the severe disparities in Australia with liver cancer, with incidence rates significantly higher than the national average in many areas in Northern Australia and many metropolitan areas of Sydney and Melbourne, due to differences in the distribution of known risk factors such as hepatitis, intravenous drugs use and excess alcohol consumption.

"In addition, other findings confirm that melanoma incidence rates are higher than the Australian average in many areas of Queensland and northern New South Wales."

Research



The online atlas is powered by myGlobe, a state-of-the-art digital system that has been developed and enhanced specifically for the atlas by the Visualisation and eResearch team at QUT.

Professor of Statistics at QUT, Kerrie Mengersen, said the atlas was designed to be user-friendly, with robust information and innovative visual presentations to help people interpret and understand the statistics.

"It can be added to and updated regularly so that all Australians can have access to the latest available information," Prof Mengersen said.

"This project has been an exciting and rewarding one to work on, to build statistical models from the registry data gathered and to present this information in an easy-to-navigate, interactive tool.

"We believe the atlas will be an important resource, of benefit to all Australians, and hope it will drive policy and research so that we eliminate disparities across Australia in levels of cancer care, resourcing and survival."

The Australian Cancer Atlas can be found at https://atlas.cancer.org.au and is ready to be used from the site.

Telehealth revolutionising diabetes management and costs

Telemedicine is providing better care at lower cost for diabetes patients in rural and remote areas.

This is according to a James Cook University (JCU) study that shows telelmedicine to be boosting the health of diabetes patients, saving them money and taking pressure off the health budget.

Nisha Nangrani, a sixth-year medical student at JCU, found the Diabetes Telehealth network operating from Townsville Hospital is making significant gains in helping diabetics to manage their symptoms.

The service enables remote patients to have regular consultations with a Townsville Hospital endocrinologist via satellite link.

The study found that patients with lifestyle-related Type 2 diabetes, as well those with uncontrolled diabetes (wildly fluctuating blood sugar levels) and hyperglycaemia (consistently high blood sugar levels) scored the biggest improvements.

Research

The research reveals that patients, who previously travelled to Townsville for face-to-face consultations, showed a 20 per cent improvement in their hyperglycaemic levels after they switched to telehealth care.

The economic benefits to the Queensland healthcare system are yet to be further explored but the Diabetes Telehealth project has shown it is generating substantial cost savings, as well as better health outcomes.

"We are doing something that seems to benefit almost everyone involved. It's better for the patient. It's easier and more convenient for endocrinologists. We're saving the healthcare system money," Ms Nangrani said.

Over the past eight years, the Baker Heart and Diabetes Institute has been involved in remote diabetes services and have highlighted the extreme levels of ill health associated with poorly controlled diabetes in these communities.

The remote clinical services they visit are generally ill-equipped to manage complex chronic disease and the type of diabetes we see is aggressive and unusually resistant to treatment.

While the study did not investigate patient satisfaction levels, the researcher believes that access to the telehealth service boosted patient motivation.

"Because we are trying not to inconvenience them by making them travel all the way to Townsville just to see a doctor, they're happy with the way they are receiving health care and more motivated to look after their diabetes," she said.

Addictive vaping growing more popular with Aussie youth

New research shows e-cigarette use to be increasingly popular among young Australians.

The research, first published in the *Australian and New Zealand Journal of Public Health (ANZJPH)* and funded by Healthway, found that young e-cigarette users in Australia have a strong preference for flavoured varieties of vaping products.

Fruit flavours are particularly popular. E-cigarettes containing nicotine are also widely popular with young Australians.

The study included an online survey of more than 1100 young adults aged 18 to 25 in Australia.

Lead author Dr Michelle Jongenelis, Research Fellow at Curtin University's School of Psychology, said: "These results show what many health professionals have suspected for some time now, that young people are indeed vulnerable to the marketing and advertising of electronic cigarettes and even those who have never smoked traditional cigarettes are increasingly interested in trying these devices.

"E-cigarettes are often marketed as a harmless yet glamorous product. They are available in a mind-boggling number of flavours designed specifically to appeal to young people. The fact that young Australians are responding to this marketing is highly concerning given the lack of evidence of the safety of the devices."

There are widespread concerns among health professionals that the chemicals, heavy metals and additives in e-cigarettes pose risks to health including impaired breathing, cellular-level damage, changes to blood pressure and heart rate, and adverse effects on the nervous system.

In response to this new evidence, the Public Health Association of Australia said Australian Governments need to take the findings seriously and act accordingly.

"This should ring warning bells and highlights the need for greater vigilance around regulation and monitoring of such devices," chief executive Terry Slevin said.

"The prime concern, at a time when a tiny number of teenagers are taking up smoking tobacco, is that these devices are harmful, addictive and may be used as a gateway to traditional cigarettes."

As of 2016, fewer than one per cent of Australian children aged 12 to 15 year had ever tried smoking cigarettes, following decades of increasing tobacco control measures and awareness campaigns by Governments and health groups.

Yet this latest study suggests vaping is fast becoming the smoking product of choice for Australian youth.

A total of 89 per cent of the young people in the latest survey who used e-cigarettes prefer the flavoured varieties. Two thirds of young users preferred e-cigarettes with nicotine.

"(This) shows the potential for addiction to these devices. Their use as a gateway to smoking traditional cigarettes is a likely risk," Dr Jongenelis said.

"It is critical we do everything in our power to resist any slide backwards on tobacco control in Australia. Until we have more data on the risks of e-cigarettes as a gateway to regular smoking there is a need for increased vigilance in regulation of the devices."

**** See also World News page 29***

Research

Will a Wii help relieve your back pain?

A University of Sydney study has shown promising results for reducing chronic back pain when patients undergo a home-based video game program of activity.

But the game must be one where they practise flexibility, strengthening and aerobic exercises for 60 minutes, three times per week at home.

The exercises are undertaken without therapist supervision, and the effect of the eight-week video-game program was comparable to exercise programs completed under the supervision of a physiotherapist.

Published in *Physical Therapy* journal, this first-of-its-kind study investigated the effectiveness of self-managed home-based video game exercises in people over 55 years using a Nintendo Wii-Fit-U.

"Our study found that home-based video game exercises are a valuable treatment option for older people suffering from chronic low back pain as participants experienced a 27 per cent reduction in pain and a 23 per cent increase in function from the exercises," said Dr Joshua Zadro, a physiotherapist and postdoctoral research fellow from the University of Sydney School of Public Health.

Dr Zadro also said the interactive video treatment program was shown to be extremely motivating and the resulting compliance to this program was much higher than other trials that have instructed patients to exercise without supervision.

Poor compliance to unsupervised home exercises continues to be a concern for treatment options with low back pain sufferers. Another bonus, the research suggests is that older people with poor physical functioning also prefer home-based exercises as travelling to treatment facilities can be difficult.

"These exercise programs could be a unique solution to increase older people's motivation to self-manage their chronic LBP through home exercise and improve their ability to continue with their daily activities despite having pain," he explained.

A recent paper in the *Lancet* discussed how low back pain is becoming rapidly prevalent in in high-income countries and a major global challenge. The *Lancet* article also discussed the challenges for treatment and highlighted the need for low cost and accessible treatments for a condition that is expected to to triple by 2050, in the population over 60 years old.

The Australian Institute of Health and Welfare (AIHW) estimates that one in six Australians (16 per cent, equalling 3.7 million people) reported back problems in 2014–15.

The AIHW also says that back problems are among the most commonly managed conditions in general practice. In 2015–16, 3.1 of every 100 GP-patient encounters were for the management of back problems — about 3.7 million GP encounters. This has increased significantly from 2.6 of every 100 GP-patient encounters in 2006–07.

US campaign tells kids vaping is crap

The Food and Drug Administration in the US has launched an ad campaign to discourage teenagers from vaping.

The campaign, described by FDA officials themselves as irreverent, uses special effects and targets the teenagers on social media and even in school toilets.

Bathroom wall posters include messages such as: "Strangely enough, some kids come here to put crap into their bodies."

The social media part of the campaign targets kids on school lunch breaks who look up a YouTube videos. They will be shown the FDA ads as well.

Appealing to teenage vanity (because appealing to their health doesn't always work), the ads depict nicotine as crawling through their bodies and disfiguring their faces.

The campaign is deliberately designed to keep clear of adult smokers who have turned to e-cigarettes in an effort to quit smoking.

The message to the teenagers, however, is that e-cigarettes deliver nicotine to addict them, and toxins that could have unexpected effects on their health and their appearance.

"We are acting on very clear science that there's an epidemic on the way," FDA Commissioner Dr Scott Gottlieb said, while also stressing that e-cigarettes are a "tobacco product".

Mitch Zeller, director of the FDA's Center for Tobacco Products stressed the point.

"E-cigarettes are now the most commonly used tobacco product among young people in the United States," he said.

"We need to get the word out about the dangers of e-cigarette use among adolescents."

The FDA has repeatedly described e-cigarette use among teenagers as an epidemic. The authority has threatened to ban flavoured vaping products, saying they are clearly marketed to addict teenagers.

CHRIS JOHNSON

Health leaders challenge global policy makers on cancer

Global health leaders have put out an urgent call to countries to improve action on cancer services.

At the World Cancer Leaders' Summit (WCLS) in Kuala Lumpur, Malaysia, on October 1, health leaders from United Nations agencies, the non-profit and private sectors, and academia came together to issue the call.

They asked countries to increase access to, and investment in, cancer services to improve vital early detection, treatment, care, and public health data.

Insisting that the need for global action on cancer was more urgent than ever, the group presented new data from the International Agency for Research on Cancer (IARC) estimating that there will be 18.1 million new cancer cases diagnosed and 9.6 million cancer deaths in 2018.

This means that countries are way off-course to meet the ambitious global target of reducing premature deaths from non-communicable diseases (NCDs), like cancer, 25 per cent by 2025 as agreed by the World Health Organisation in 2013, they said.

Union for International Cancer Control President, Professor Sanchia Aranda, said: "Cancer is not just a health concern, but also a serious threat to development. The growing burden has clear implications for patients, their families, and health systems, but also for the economic growth of a country as a whole."

UICC President-elect, HRH Princess Dina Mired said: "We know Treatment for All is possible in every country. What we need is strategic national plans and national champions for cancer control to implement these measures."

CHRIS JOHNSON

WMA calls for stronger physician-led health care systems worldwide

World Medical Association President Dr Yoshitake Yokokura has called on world leaders to strengthen healthcare systems based on physician-led primary care.

Using a United Nations General Assembly meeting in New York discussing non-communicable diseases (NCDs), Dr Yokokura welcomed the Political Declaration on the prevention and control of NCDs.

The emphasis of the declaration is on strengthening the link between NCDs and the social-economic and environmental determinants of health.

Dr Yokokura added, however, that he regretted the declaration does not include clear and measurable commitments.

He said the WMA is particularly concerned by the lack of specific commitments and targets for funding. The WMA is advocating for the inclusion of more NCDs to avoid a silo approach.

"Health care professionals see first-hand the devastating impact of NCDs on patients and their families," Dr Yokokura said.

"Physicians are treating an increasing number of cases and are seeing more and more complex cases. NCDs are increasing the bill and burden on already under-resourced health care systems.

"In the light of the expected increased demand for 18 million more health workers, primarily in low and lower middle-income countries by 2030, healthcare system strengthening is of the utmost importance to reduce the growing burden of NCDs."

The WMA called for UN member states to use the momentum of the declaration to set ambitious country targets, to commit to additional funding for NCDs and to draw up policies and measures in country action plans which aim to support.

CHRIS JOHNSON

American crackdown on opioids

The United States Senate has overwhelmingly approved a string of bills aimed at fighting head-on America's opioid epidemic.

The far-reaching legislative package had bipartisan support and was passed 99-1.

Republican Senator Mike Lee from Utah was the only one to vote against it.

The House of Representatives passed similar legislation in June, with both houses of Congress now taking direct aim at the opioid crisis.

The Senate's *Opioid Crisis Response Act of 2018* directs funding to federal agencies to establish or expand programs dealing with prevention, treatment and recovery.

The 70 bills in the package include the *Trafficking and Overdose Prevention Act 'STOP' Act*, which was endorsed by President Donald Trump. It sets up a framework to stop shipments of fentanyl, a synthetic opioid, from entering the States.

Other bills include requiring the Food and Drug Administration to

give prescription opioid pills in smaller quantities, and funding to the National Institutes of Health to develop of non-addictive painkillers.

Opioid overdose deaths in America in 2017 is estimated at 72,000.

CHRIS JOHNSON

Escaping to sanctuary in the Swiss Alps

BY CHRIS JOHNSON

Let's face it. You've seen one church you've seen them all.

Every European city is rightly proud of its cathedral, but after Notre Dame what's left to impress?

Well... St Peter's Basilica, Westminster Abbey, the Kaiser Wilhelm Memorial for starters.

Then there's Asia. Magnificent temples everywhere.

It seems history is full of worshiping people, cities and countries who have gone to great lengths to out-do their neighbours when it comes to building their religious edifices.

A pub crawl could feasibly quite easily turn into a holy shrine crawl if you let tour guides have their way.

Which is one reason why I shun guided tours and opt for the create-your-own-adventure holiday – mistakes and all.

It is also why, after a week-and-a-half soaking up the delights of Italy (cathedrals included), a getaway in the Swiss Alps was the perfect finale to delightful vacation.

And stumbling across this little chapel on a mountainside in Belalp did more to feed my soul than all the monks of Europe ever could.

I didn't go inside. I'm not sure what denomination it is, if any. I don't even know if it was a functioning church or a converted B&B. It is surely used as a wedding chapel.

But it looked as magnificent as the Duomo of Florence.

Arriving in the car-free village of Belalp by cable car from Blatten, a short walk to my Hotel Belalp destination and the chapel is unmissable. It is literally in the hotel's backyard.

After a day's hiking the mountain trails, surrounded by breath-takingly stunning views of snow-capped landscape and the jaw-dropping Aletsch Glacier, the chapel made for a welcoming landmark on the return. Or as Quasimodo might have said – sanctuary.

Switzerland enjoyed an unusual heatwave in its summer this year (although the Swiss don't really know what a heatwave is), and while there was plenty of snow to be seen, it could be done in t-shirts and shorts.

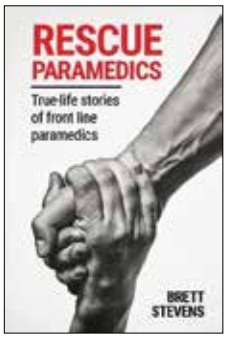
In winter, Belalp is a ski resort. In summer it is just as seductive.

With the imposing Matterhorn standing tall in the distance in front of us and this cute little chapel perched on the doorstep directly behind, it was eye candy everywhere I looked.

Perhaps it was the friendly goats who came to greet us – definitely it was the scenery – but I couldn't help thinking that this really is the only way to have an uplifting experience at church.

Book Review

REVIEWED BY **CHRIS JOHNSON**



Rescue Paramedics

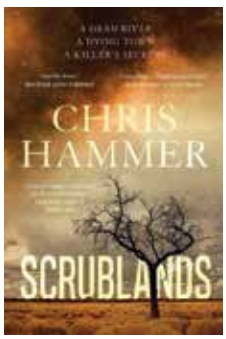
By Brett Stevens

New Holland Publishers

Sub-tiled *True-life stories of front line paramedics*, this book is a riveting read about the often unheralded work of those first on the scene of so many tragedies and accidents ... as well as some of life's most uplifting experiences.

Births, deaths, rescues, burns, overdoses, stabbings, shootings, crashes, and crash-throughs are all described in these pages with humanity and powerful insight.

Extremely well written and easy to read, *Rescue Paramedics* is a fitting tribute to those who put themselves on the line to be there when duty calls and people need help.



Scrublands

By Chris Hammer

Allen & Unwin

A page turner! This crime, thriller, suspense novel is simply brilliant.

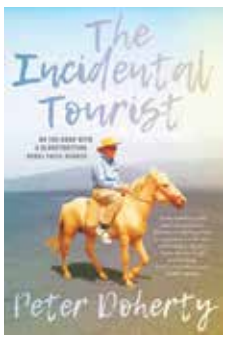
Set in a dying rural town of the Australian Riverina, this is more a "why-done-it?" than a "who-done-it?".

The crime is revealed in the first paragraphs of the book and the rest of the journey sets about trying to untangle what seems to be a very messy web.

Hammer's prose is beautiful. And he defiantly wraps up myriad sub-plots just when you think the task impossible.

You can feel a part of this tight-knit community that has more dark secrets and seedy characters than any town should.

There is a very good reason that *Scrublands* hit the bestsellers list immediately and has stayed there.



The Incidental Tourist

By Peter Doherty

Melbourne University Press

Nobel Prize winner Peter Doherty has written an amazing travel journal, weaving his knowledge of science and medicine with his love of far-flung destinations.

A very enjoyable read, this memoir crosses the globe as well as the decades and all the while posing the deepest of questions, such as "What the hell am I doing here?".

Doherty won the Nobel Prize in Medicine or Physiology 1996 for discovering the nature of the cellular immune defence.

His intellect, humour and good nature are all evident in these pages.

Lithium – Power to the people

BY DR CLIVE FRASER

It's been 70 years since an Australian ex-Changi POW named Dr John Cade treated his first patient with lithium.

On March 29, 1948, Dr Cade commenced treating Mr WB who was described as: "A male, aged fifty-one years, who had been in a state of chronic manic excitement for five years, restless, dirty, destructive, mischievous and interfering, (he) had long been regarded as the most troublesome patient in the ward."

Cade went on to state that: "His response (to lithium) was highly gratifying. From the start of treatment ... with lithium citrate he steadily settled down and in three weeks was enjoying the unaccustomed surroundings of the convalescent ward."

Cade said that with lithium treatment Mr WB: "remained perfectly well and left hospital on July 9, 1948, on indefinite leave with instructions to take a maintenance dose of lithium carbonate, five grains twice a day."

In today's money that's 330mg bd, which is uncannily similar to a 21st century lithium dose.

With bipolar disorder continually in the top ten in Global Burden of Disease reports one might have thought that Dr Cade was worthy of a Nobel Prize.

But his revelation went largely unheralded in the United States.

It seems that a big hurdle there was a US decision to ban lithium from soft drinks.

From 1929 until 1950 anyone who purchased 7 Up (aka Lithiated Lemon Soda) was getting an extra dose of lithium in their liquid refreshment.

Sure, from 1886 until 1929 Coca-Cola had actually contained cocaine, which was later replaced with caffeine.

So, the idea of removing drugs from food and beverages had merit.

But it wouldn't be until 1970 that the US Food and Drug Administration would list lithium as a treatment for Bipolar Disorder, after it had already been approved by 49 other countries, and 21 years after Cade's first publication in the *Medical Journal of Australia*.

Lithium was named from the Greek word *lithos*, meaning stone.

In its pure form it is shiny and metallic.

It was discovered in 1817 by a Swedish chemist (Johan August Arfwedson) in naturally occurring Petalite.

In 1923 a German company (Metallgesellschaft AG) began commercial production and by 1939 lithium was being added to

grease to increase its usable temperature to 120 °C.

This ability to extend the thermal properties of a product saw its use in the production of CorningWare, a product that could withstand a sudden temperature differential of 450 °C.

In the form of petalite it was also used as a heat-resistant material for the nose cones of ballistic missiles.

Oh, and lithium turns up in all sorts of other places in weaponry.

If lithium 6 is bombarded with neutrons in nuclear reactions tritium is produced. Under extreme temperatures and pressures, tritium atoms fuse with deuterium to release both neutrons and large amounts of energy.

This fusion reaction is the key to the hydrogen bombs that are far more destructive than the atomic bombs used at Hiroshima and Nagasaki

The United States has a stockpile of 42,000 tonnes of lithium hydroxide, just in case.

With an atomic number of three and an outer available valence electron lithium has just the right chemical structure for use in batteries.

Lithium-ion batteries were being used in implantable medical devices long before they found their way into smartphones.

But lithium batteries in cars is really where the future lies

The price of lithium has surged by 45 per cent in the past year which might give some indication of where the use of lithium is heading.

Dr Cade is hopefully looking on with some degree of comfort that his pioneering research with lithium has helped so many.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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AMA members requiring assistance can call AMA member services on **1300 133 655** or **memberservices@ama.com.au**

Jobs Board: Whether you're seeking a new position, looking to expand your professional career, or looking to recruit staff to your practice, doctorportal Jobs can help you. Discounts apply for AMA members. jobs.doctorportal.com.au

MJA Events: AMA members are entitled to discounts on the registration cost for MJA CPD Events!

UpToDate: UpToDate is the clinical decision support resource medical practitioners trust for reliable clinical answers. AMA members are entitled to discounts on the full and trainee subscription rates.

doctorportal Learning: AMA members can access a state of the art CPD tracker that allows CPD documentation uploads, provides guidance CPD requirements for medical colleges, can track points against almost any specialty and provides access to 24/7 mobile-friendly, medical learning.

Learning.doctorportal.com.au

MJA Journal: The Medical Journal of Australia is Australia's leading peer-reviewed general medical journal and is a FREE benefit for AMA members.

Fees & Services List: A free online resource for AMA members. The AMA list of Medical Services and Fees provides an important reference for those in medical practice to assist in determining their fees.

Career Advice Service and Resource Hub: This should be your "go-to" for expert advice, support and guidance to help you navigate through your medical career. Get professional tips on interview skills, CV building, reviews and more - all designed to give you the competitive edge to reach your career goals.

www.ama.com.au/careers

Amex: As an AMA member, receive no-fee and heavily discounted fee cards with a range of Amex cards.*

Mentone Educational: AMA members receive a 10% discount on all Mentone Educational products, including high quality anatomical charts, models and training equipment.

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AMP: AMA members are entitled to discounts on home loans with AMP.

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Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

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HIGHLIGHTS FROM OUR LEARNING CATALOGUE

Concussion in Sport

Use the latest evidence-based information to better diagnose concussion in sport related activities.

Advance Life Support Certification

The only accredited ALS certification in Australia that enables you to undertake the clinical assessment via a virtual platform.

AMA Code of Ethics

It's essential to understand the ethical principles needed to best support your patients as they make their own informed health care decisions.

COMING SOON:

Medicare Billing Compliance

A Good Life – An end of life conversation worth having

Writing Medical CV's

cpd

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