AUSTRALIAN Medicine

The national news publication of the Australian Medical Association

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AUSTRALIAN

Medicine

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Clinical adviser to assist aged care commission thanks to AMA

Australia's first independent Aged Care Quality and Safety Commission has been approved by the Federal Parliament, with legislation passing in November.

It will begin operations on January 1, 2019.

In addition, a Chief Clinical Advisor will be appointed to assist the new Commission.

> "The AMA has continuously called for the establishment of a Commission that provides a clear, well-communicated governance hierarchy, which brings leadership and accountability to the aged care system."

The Advisor role was created following strong advocacy from the AMA for such a role.

The Federal Government amended its *Aged Care Quality and Safety Commission Bill 2018* to formally enshrine the position of Chief Clinical Advisor to assist the new Commissioner.

The Health Department has confirmed that the Chief Clinical Advisor will be a doctor.

AMA President Dr Tony Bartone said the AMA insisted that a Chief Clinical Advisor had to be appointed and that the role be filled by a medical professional.

"The Carnell-Paterson Review, which was initiated in response to the shocking failures at the Oakden facility in South Australia, recommended establishing an independent aged care Commission to centralise regulation," Dr Bartone said.

"The AMA has continuously called for the establishment of a Commission that provides a clear, well-communicated governance hierarchy, which brings leadership and accountability to the aged care system.

"In our *Position Statement on Resourcing Aged Care*, in our submission to the Inquiry into the Bill, and during our public evidence to the Inquiry, the AMA consistently argued that having a Chief Clinical Advisor is an absolute must for the Commission.

"Further, the AMA argued that the Chief Clinical Advisor must be a registered medical practitioner, ideally either a GP or a geriatrician, with strong expertise in aged care.

"Doctors are the primary coordinators and providers of clinical care to older people, and are best placed to fill the Advisor role.

"The AMA has for some time advocated for more consideration of clinical matters when regulating the aged care sector.

"The AMA looks forward to working with the Commissioner and the Chief Clinical Advisor with a goal to improve older people's much-needed timely access to quality clinical care."

Aged Care Minister Ken Wyatt said senior Australians were at the heart of the reforms.

"The role of the Commission will be to implement a strong but fair regulatory framework that will protect and enhance senior Australians' quality of life, safety, health and wellbeing," Mr Wyatt said.

"Led by independent Commissioner Janet Anderson, the Commission will better target aged care homes that provide sub-standard care and will be a single, trusted point of contact for aged care recipients, their families and loved ones, and aged care providers."

The Commissioner will determine the scope of the Advisor's work, but the role is likely to cover:

- regulation of, and compliance with, the Aged Care Quality Standards, including provider's performance in clinical care and governance, and reducing infections and restraint use;
- complaints resolution; and
- education to providers and their staff, consumers, and the public, around clinical issues.

The Chief Clinical Advisor, who will support the Commissioner, will themselves be supported by an expert clinical panel.

CHRIS JOHNSON

Medical Board's revised sexual boundaries guidelines to take effect

Strengthened guidelines on sexual boundaries for doctors when dealing with their patients are set to kick in.

The revised Medical Board of Australia guidelines on sexual boundaries in the doctor-patient relationship take effect on December 12 this year.

The guidelines remind doctors that trust in the relationship between doctors and patients is a cornerstone of good medical practice.

Medical Board Chairwoman, Dr Anne Tonkin, said sexual misconduct is an abuse of the doctor-patient relationship and can cause significant and lasting harm to patients.

"Patients have a right to feel safe when they are consulting a doctor," Dr Tonkin said.

"Patients trust doctors to act in their best interests, treat them professionally, protect their privacy and never take advantage of them.

"It's hard to believe that in 2018, there is still a need for the Board to issue guidance on the importance of sexual boundaries between doctors and patients.

"While the vast majority of doctors in Australia provide the community with excellent medical care, a small number of doctors cause serious harm to patients when they do not maintain sexual boundaries."

Breaches of sexual boundaries in the doctor-patient relationship are one reason the Medical Board refers doctors to tribunals for disciplinary action. In 2017/18, ten cases involving allegations of serious sexual misconduct were decided by tribunals – all received an adverse finding.

The updated guidelines apply to all registered medical practitioners in Australia and define the standards of ethical and professional conduct expected of doctors by the Board, their peers and the community.

They complement *Good medical practice: a code of conduct for doctors in Australia* and do not change the ethical and professional conduct expected of doctors.

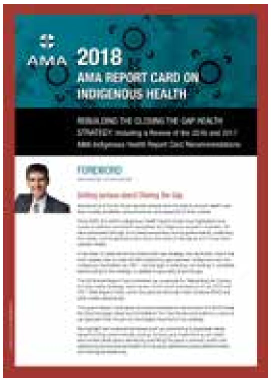
The revised guidelines replace the current guidelines, *Sexual boundaries: guidelines for doctors*. They follow a scheduled review, supported by wide-ranging stakeholder consultation.

The guidelines remind doctors that:

- it is never appropriate for a doctor to engage in a sexual relationship with a current patient;
- a doctor must only conduct a physical examination of a patient when it is clinically indicated and with the patient's informed consent;
- good, clear communication is the most effective way to avoid misunderstandings in the doctor-patient relationship; and
- doctors are responsible for maintaining professional boundaries in the doctor-patient relationship.

The key changes to the guidelines include:

- a change in the title to make the scope of the guidelines clearer;
- editorial updates that reorder the content, make it easier to read and clarify terms and definitions;
- a new section on social media that complements the Board's Social media policy;
- a requirement for patient consent if medical students or anyone else is to be present during an examination or consultation;
- advice that an unwarranted physical examination may constitute sexual assault. This includes conducting or allowing others, such as students, to conduct examinations on anaesthetised patients, when the patient has not given explicit consent; and
- replacing the term 'chaperone' with the term 'observer'. The revised section on the use of observers reflects the advice and principles in Professor Ron Paterson's report of the *Independent review of the use of chaperones to protect patients in Australia*, February 2017.



AMA
2018
AMA REPORT CARD ON
INDIGENOUS HEALTH

FOREWORD

Indigenous Health Report Card launched

AMA President Dr Tony Bartone has launched the AMA *Indigenous Health Report Card 2018*, calling for a new strategy to be built if the gap between Indigenous and non-Indigenous life expectancy is to be closed.

The strategy must be rebuilt, not refreshed, Dr Bartone said.

"If anything, the gap is widening as Aboriginal and Torres Strait Islander health gains are outpaced by improvement in non-Indigenous health outcomes.

"The strategy has all but unravelled, and efforts underway now to refresh the strategy run the risk of simply perpetuating the current implementation failures.

"The strategy needs to be rebuilt from the ground up, not simply refreshed without adequate funding and commitment from all governments to a national approach."

Next week's print edition of *Australian Medicine* will focus on the Report Card's findings. Some highlights of Dr Bartone's visit to Indigenous health services in Queensland are included here in the following stories.

The AMA *2018 Indigenous Health Report Card* is at https://ama.com.au/article/2018-ama-report-card-indigenous-health-rebuilding-closing-gap-health-strategy-and-review

CHRIS JOHNSON

Mental health critical to closing the gap

Mental health in the Aboriginal and Torres Strait Islander population must be tackled urgently if any progress is to be made on closing the health and life expectancy gaps, the AMA Indigenous Health Report Card 2018 warns.

Suicide was the second leading cause of death for Indigenous males in 2017, according to the Australian Bureau of Statistics (ABS), and the rate of suicide deaths in the Indigenous population has increased by 21 per cent between 2008 and 2017.

"In short, the suicide and the mental health gaps had likely only increased since 2011, and must be addressed if the health and life expectancy gap is to close," the Report Card says.

"The [Closing the Gap] Strategy needs to rebuilt with mental health prioritised alongside chronic disease. Without such an additional mental health focus, a merely 'refreshed' and underfunded Closing the Gap Strategy will not only be remiss in failing to target a major contributor to health inequality, it will not reflect the evidence base."

Trauma and intergenerational trauma significantly affects social and emotional wellbeing and mental health across the population, the Report Card says.

"About 17,150 members of the Stolen Generations are still alive today, and they experience much higher levels of adversity in relation to almost all health and welfare outcomes, much of which relates to untreated and unhealed trauma," it said, citing a 2018 report from the AIHW and the Aboriginal and Torres Strait Islander Healing Foundation.

The Report Card endorsed Recommendation Four of the 2018 Close the Gap Campaign Steering Committee's Ten-Year Review, which called on Australian governments to commit to making Indigenous mental health a national priority in the refreshed Strategy, and to systematically cost, fund, and implement the National Strategic Framework for Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing.

"Developing [these] plans was an important activity, but it is now time to turn the page," the Report Card says.

"The next 10 years of the rebuilt Closing the Gap Strategy must be about providing equitable funding for Aboriginal and Torres Strait Islander health, including for the systematic implementation of the plans.

"It's time to roll up our collective sleeves and deliver on them."

MARIA HAWTHORNE

Deadly Choices saving lives

Aboriginal & Torres Strait Islander Community Health Service Chairwoman Karina Hogan and Dr Bartone.

Deadly Choices is one of the most visible signs of the work of the Institute for Urban Indigenous Health (IUIH).

Deadly Choices shirts, baby onesies, and posters adorn the walls of all IUIH clinics. The front windows are plastered with posters featuring Deadly Choices Ambassadors – Indigenous sports stars who promote the message of healthy choices.

And the Deadly Choices shirts can't be purchased – they are only given to Aboriginal and Torres Strait Islander people who have had a health check at a clinic.

"When I see people walking around in a Deadly Choices shirt, I know that that person has had a health check," Shadow Assistant Minister for Indigenous Health, Warren Snowdon, told the audience at the launch of the AMA Indigenous Health Report Card 2018 recently.

The program uses the Aboriginal slang term "deadly", which means "great", to encourage Aboriginal and Torres Strait Islander people to make healthy choices for themselves and their families every day – to stop smoking, to eat good food, and to exercise daily.

It started in south-east Queensland in 2010 at four independent community controlled health services, and has since expanded to more than 35 primary health clinics.

Deadly Choices encourages Indigenous people to visit their local health service and complete a health check every nine to 12 months, to normalise the idea of seeing a doctor not just when sick, but to remain healthy and prevent or better manage chronic disease.

As an incentive, the shirts change annually, and can be branded with the name of an individual Ambassador, including rugby league legends Steve Renouf, Preston Campbell, Petero Civoniceva, and Scott Prince, Jillaroo Tallisha Harden, Olympic sprinter Patrick Johnson, and body builder Rhonda Purcell.

In 2017-18, almost 21,000 health checks were conducted, and more than 10,500 new patients were engaged, taking the total number to 35,020.

The Deadly Kindies program has also helped boost the number of Indigenous children attending kindergarten. Parents who take their child into their health service for a pre-kindy health check and enrol their child in kindergarten receive a free kindy kit – a backpack filled with kindy items like a lunchbox, blanket, and pillow case – worth about $75.

AMA President, Dr Tony Bartone, was presented with his own personalised Deadly Choices shirt at the Report Card launch.

MARIA HAWTHORNE

Mums and Bubs Hubs slash pre-term births

AMA President Dr Tony Bartone with staff at the Salisbury Mums and Bubs Hub

In suburban streets all over south-east Queensland, an extraordinary program is changing the lives of pregnant Indigenous women and their families.

Birthing in Our Community (BiOC) is a collaboration between the Institute for Urban Indigenous Health (IUIH), Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane, and the Mater Health Service.

BiOC, run from Mums and Bubs Hubs at the 20 IUIH clinics from the Gold Coast to Caboolture to Laidley in the Lockyer Valley, aims to identify Indigenous pregnancies – where either parent is Indigenous – as early as possible, and offers culturally appropriate 24/7 care throughout the pregnancy, and six weeks of postnatal care by a dedicated midwife.

Since its launch in August 2013, BiOC has reduced preterm births by 50 per cent to 8 per cent - lower than the national non-Indigenous rate - and has increased its Indigenous workforce by 550 per cent.

More than 600 women have had a 24/7 known midwife and family support worker, and almost nine in 10 of those women had five or more antenatal visits.

“If this program was in Cape York, we’d have a Nobel Peace Prize,” IUIH chief executive officer Adrian Carson said.

Transport workers – some of them mothers who have gone through the program themselves – ferry clients to and from appointments.

Family support workers visit the girls and women at their homes for their first appointment, and also sit in on appointments with midwives, to explain any medical language.

Centrelink and Department of Housing staff attend the clinic monthly, and every Friday is “community day”, where clients are encouraged to find where their passion lies, whether it be cooking, face painting, sewing, or another pastime.

When the women go into labour, their midwife meets them at the hospital, as “a friendly face in a familiar shirt”, Dr Claire Maguire says.

Most of the women go home as quickly as possible, usually after four hours, and their midwife sees them daily for up to six weeks after the birth.

On a recent visit to the Salisbury Mums and Bubs Hub on Brisbane’s southside, AMA President Dr Tony Bartone met staff at the centre, including Kylie and Gwen, who have both become midwives.

Kylie had her own baby midway through her midwifery degree.

“Now I want to give back and support other students,” she said.

Gwen said she had been inspired to pursue midwifery as a pregnant 17-year-old by an Aboriginal midwifery nurse who would drive around in the community and drop off medical supplies like iron tablets.

“I was 17, having a child, and I didn’t feel secure around the people who were supposed to be caring for me,” she said.

“I want to see more of our mob come through as midwives.

“I was able to go to university, and I was supported to get through. And the graduate program is culturally appropriate.”

The program is being evaluated through a longitudinal prospective birth cohort study comparing maternal and infant health outcomes between women accessing maternity care through BiOC with the Ngarrama program at the Royal Brisbane Women’s Hospital.

Women from both programs are invited to participate in surveys when they book into hospital at 36 weeks antenatally, and at two and six months postnatally. More than 600 women have been recruited into the study, which is funded by a National Health and Medical Research Council (NHMRC) partnership grant.

The study has so far produced three published papers and two that are under review – one of them by *The Lancet.*

MARIA HAWTHORNE

AMA President's focus on Indigenous health

PHOTO GALLERY

PHOTO GALLERY (continued)

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https://www.surveymonkey.com/r/25KG2PW

for your chance to win a Microsoft Surface Pro.

Thank you for your feedback and ideas.... And good luck in the draw.

Advocacy on MBS Review changes for spinal items

The AMA continues to hear about the impact of a troublesome implementation of the Government's MBS Review changes for spinal items.

The AMA recognised early on how badly the implementation of the new MBS spine items was going and called on the Government to:

- Provide the methodology and logic behind the changes, and adequate time to give the Private Health Insurance funds the chance to consider this; and
- Convene a roundtable or consultation with the AMA and the funds about what else is required to protect patients from the unexpected out of pocket expenses during the interim period, and how to avoid these issues going forward for future MBS reviews.

This involved raising the issue with the Minister and then discussing it with the leadership of the Department of Health.

In doing so, the AMA highlighted that practices around Australia faced a dilemma: who takes the cuts? Patients or practitioners?

Health insurance funds were still scrambling in late November to work out their rebate schedules for the revised items. Even where they had finally loaded a list on their websites, these were not always yet installed into billing software.

The AMA has been told by some practices around Australia that claims were being rejected by the funds (due to not having a benefit schedule finalised), with no timeframe available as to when the issue was to be resolved.

Practitioners had a choice, either they:

- Didn't put forward claims until the issue is resolved (although we are now into December and a month has passed under the new system); or
- Pass the full fee onto their patients and have them navigate the claiming themselves.

The AMA has had members say the impact went further – without rebate levels, practices are not able to bill for assistant surgeons who are critical to the effectiveness and safety of complex spinal procedures.

Practice managers were spending hours on the phones to health insurers only to be told they don't have any answers, call back later. Time spent organising and managing practices is being diverted into developing work arounds and alternative bill management structures. Officers of the AMA have spoken to many surgeons, and their practice managers, about these concerns.

Of course, as more funds try and create their rebate schedules in the vacuum, the more variability and variance in insurance rebates are being created. This is creating rebate reductions and a loss of relativity across the funds. For a Government advocating for a reduction in out of pocket expenses, a narrative in the media that blames doctors for any gaps, we cannot have a new situation that exacerbates patient out of pockets.

Thankfully, the AMA's advocacy has been heard, with the Department convening a roundtable now on December 7. The AMA has asked that the high-level decision makers from the funds be present, so that we can resolve with the Department and the Spine Society, not only the issue of the spinal item rebates, but also discuss and agree a process going forward.

Often the AMA is seen to be battling against the funds. But in this instance, it has worked to highlight the reality the funds face with implementing change.

They will need the methodology and the time to develop their benefit schedules as significant changes occur. Then the software companies and billing agencies will need time to update their systems. And finally, practices need time to adjust their billing, and most importantly, their informed financial consent processes.

The AMA's hope is that we can speak with one voice going forward to call for improvements to the process. After all, the spinal items were just 60 items – the MBS review has thousands and thousands yet to come.

BY TRACEY CROSS AND LUKE TOY

A win for consultation – reports being made public

The AMA would also like to take the time to thank all those who have responded to the call for input on the MBS Review, and to take the time to review the AMA's MBS Review website.

Please continue to feel free to provide feedback – especially now that the AMA's calls for the Government to make the MBS Review reports that are currently out for consultation publicly available – meaning AMA members can now see the reports on the Department of Health's website.

IT IS MEMBERSHIP RENEWAL TIME

THANK YOU FOR BEING AN AMA MEMBER. YOUR MEMBERSHIP KEEPS US STRONG.

There will be a Federal Election in 2019. Health policy will help determine the next Government.

Your AMA will be advocating for:

- Significant new investment in general practice
- MBS review outcomes that improve the delivery of health care
- Increased public hospital funding
- National Mandatory Reporting laws that help doctors and patients
- Better value and more transparent private health insurance
- A *My Health Record* that protects patient privacy and confidentiality
- Better health care for asylum seekers and refugees
- A greater focus on mental health
- Urgent action on aged care reform
- Strategic funding and programs to improve Indigenous health
- A reinvigorated approach to public health and prevention
- Cohesive medical workforce and training policies across all governments

The AMA is the only organisation that can cover the depth and breadth of health policy across the Federal, State/Territory, and local levels. The AMA is your partner to influence and improve health policy, and to provide advice and resources to support you in your practice and career.

The AMA is the voice of the medical profession and the voice of the patients in our care. The AMA is your voice.

Simply renew your tax-deductible membership online or contact your local AMA office.

RENEW NOW

MBS review changes to phototherapy items

From November 1, the MBS review has brought a change to the ultraviolet phototherapy items, consolidating them into one item 14050 with imposed conditions.

It has become clear that there has been both an implementation and a communication failure regarding these changes and all GPs claiming these items since November 1 have had rebates refused. As a result of an intervention from the Australasian College of Dermatologists (ACD), the Department has agreed to reconsider these claims, where the necessary documentation regarding Dermatologist supervision is present, and allow them to be resubmitted. The ACD also requested a moratorium of three months on compliance implementation to allow affected GPs to make the necessary arrangements. This has been refused by the Department, however the AMA will continue to argue this case.

Poor communication has led to affected GPs being unaware of the impending changes. This is a time of frenetic activity in the MBS Review, with numerous cascading recommendations flooding stakeholders, in this instance GP organisations, and clearly overwhelming their capability to appropriately inform their constituencies.

In the instance of the changes to phototherapy items, there is an obvious need for receipting practices to be changed but this needs to be supported by a reasonable lead-in period. The Dermatology, Allergy and Immunology (DAICC)MBS Review working group recommended a grace period which the Department has chosen not to apply, which the ACD supported because of concerns particularly for patients in rural or remote areas, or in areas of Dermatology workforce shortage where appropriate support from a Dermatologist may be difficult to arrange, in the time made available before the changes were put in place.

In the meantime, information on the change is below:

14050

UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology

Applicable not more than 150 times in a 12 month period

TN 1.14

A component for any necessary subsequent consultation has been included in the Schedule fee for this item. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

Phototherapy should only be used when:

- Topical therapy has failed or is inappropriate.
- The severity of the condition as assessed by specialist opinion (including symptoms, extent of involvement and quality of life impairment) warrants its use.

Narrow band UVB should be the preferred option for phototherapy unless there is documented evidence of superior efficacy of UVA phototherapy for the condition being treated.

Phototherapy treatment for psoriasis and palmoplantar pustulosis should consider the National Institute of Health and Care Excellence's Guidelines at https://pathways.nice.org.uk/pathways/psoriasis

Involvement by a specialist in the specialty of dermatology at a minimum should include a letter stating the diagnosis, need for phototherapy, estimated time of treatment and review date.

BY DR ANDREW MILLER

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON

Self-testing kit approved for HIV

The first HIV self-testing kit has been approved by the Therapeutic Goods Administration and a new HIV medicine has been listed on the Pharmaceutical Benefits Scheme.

The Federal Government has also announced funding for a new strategy that it says aims to virtually eliminate the transmission of HIV.

The first HIV self-testing kit, the Atomo Self Test was approved for use by the TGA on November 28. The test is a single-use rapid finger stick test for the detection of antibodies to HIV and will enable people to test for HIV in their own home.

It will make testing accessible and convenient, especially for people that need to test frequently or do not test at all.

The medicine Juluca® (dolutegravir and rilpivirine), which works to stop the replication of the HIV virus, is listed on the PBS from December 1, which is World AIDS Day.

This listing means about 860 people a year will be able to access this medicine that would otherwise cost patients up to $10,800 a year without the PBS subsidy.

Patients will now pay a maximum of $39.50 per script, with concessional patients, including pensioners, paying just $6.40 a script.

"Getting people with HIV on sustained, effective treatment is important not only for the individual's health but also because people with HIV who take treatment daily, and achieve and maintain an undetectable viral load, have effectively no risk of sexually transmitting the virus," said Health Minister Greg Hunt.

"I am also pleased to announce that the Government will commit $5 million to support the implementation of Australia's next National Blood Borne Virus and Sexually Transmissible Infections Strategies"

These include:

- The Eighth National HIV Strategy 2018–2022;
- The Fifth National Aboriginal and Torres Strait Islander BBV and STI Strategy;
- The Fifth National Hepatitis C Strategy;
- The Fourth National STI Strategy; and
- The Third National Hepatitis B Strategy.

"The Eighth National HIV Strategy will be the roadmap to help further reduce new infections and improve health outcomes," Mr Hunt said.

"Its goals include virtually eliminating HIV transmission in Australia by 2022, reducing mortality and morbidity related to HIV and supporting those living with HIV by reducing stigma and discrimination.

"A few short years ago defeating HIV was seen as impossible but today we are on the cusp of eliminating the transmission of HIV."

In 2017, more than 27,000 people were living with HIV in Australia.

Last year, Australia recorded 963 HIV notifications—the lowest annual number of notifications since 2010.

There has been a reduction of 15 per cent in diagnoses among gay and bisexual men in the past year alone.

"I am proud to say that our Government is taking decisive action with a range of measures to address HIV in our community," the Minister said.

"These important announcements today come on top of our Government's decision this year to list the daily preventative medication known as PrEP on the PBS on 1 April 2018.

"The $180 million listing of PrEP, on the PBS, benefits up to 32,000 patients who would otherwise pay $2,496 a year without the subsidy. By listing PrEP we put Australia in reach of being one of the first countries in the world to end transmission of HIV.

"Since the first HIV diagnosis in Australia more than 30 years ago, our understanding around prevention, transmission and treatment of HIV has improved significantly."

Australia's theme for World AIDS Day 2018 is 'Everybody Counts'. World Aids Day is about ensuring people with HIV can participate fully in the life of the community, free from stigma and discrimination.

The strategies are available on the Department of Health website www.health.gov.au/sexual-health

Submissions from medics sought for thalidomide inquiry

The Senate Community Affairs References Committee is seeking further evidence in its examination of support provided to Australia's thalidomide survivors and has decided to extend its reporting date to February 13, 2019 to facilitate this.

The Committee has already held a public hearing in Melbourne on November 2, 2018 and has received more than 50 written submissions.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p14

"At the Committee's hearing in Melbourne we were able to hear first-hand the lived experience of thalidomide survivors and their families," said Committee Chairwoman Senator Rachel Siewert.

"This gave us an insight into the impact thalidomide injuries have on survivors' lives and the health and financial challenges they continue to face.

"The Committee recognises that thalidomide survivors' circumstances are highly individualised and survivors are best placed to inform the committee regarding their future health and support requirements."

At the same time, the Committee would like to hear from others in the community who have experience or knowledge that will assist the committee to understand the needs of thalidomide survivors and the financial and practical support they require.

"We would welcome submissions from medical practitioners, disability advocates, academics and other professionals who might be able to assist us," Senator Siewert said.

While the initial date for lodging submissions has passed, the Committee will still accept submissions to the Inquiry. Submissions can be emailed to community.affairs.sen@aph.gov.au

The Committee plans to have a second public hearing in Sydney on January 31, 2019.

To participate in this hearing, contact the Committee's secretariat by email or telephone. Arrangements for the hearing will be posted on the Inquiry webpage:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ThalidomideSurvivors

The webpage has a range of information about the inquiry, including its terms of reference, public submissions and the transcript of the committee's Melbourne hearing.

AMA tells Canberra that obstetricians must lead maternity services

The AMA insists that national maternity services must use a collaborative care model that is led by obstetricians or general practice obstetricians.

It has said exactly that in its submission to the Commonwealth Department of Health and Ageing on the proposed new National Maternity Services Strategy.

AMA President Dr Tony Bartone said best-practice maternity care in the 21st century is provided by a multi-disciplinary team of health professionals.

"Obstetricians are the leaders and, along with midwives, are the key carers, but the team also includes general practitioners, anaesthetists, psychiatrists, obstetric physicians, pathologists, haematologists, paediatricians, and nurses," Dr Bartone said.

"Current evidence supports that this model of care – led by an obstetrician or GP obstetrician – is the safest for mothers and babies, and optimises a range of other health outcomes.

"Obstetrician-led or GP obstetrician-led care means that, at a minimum, there will be initial assessment by either an obstetrician or GP obstetrician, and assessment and regular review during labour.

"Models of care should not result in situations where obstetricians only become aware of a labour problem once it has become acute or serious.

"Women should be encouraged and supported to make their own choices about their maternity care.

"But they should be fully informed about the risks and benefits of each model as it relates to their own specific health situation, pregnancy, and circumstances, after assessment by an obstetrician or GP obstetrician.

"In many instances, GPs are the health professionals who start the conversation with women about having children.

"GPs are best placed to provide continuity of care for women before, during, and after their pregnancies.

"And GPs are especially important in providing whole of maternity care for women in rural and remote communities."

Dr Bartone said significant additional Federal Government funding will be needed to ensure safe, high-quality, and easily accessible maternity services across Australia.

The AMA used the following principles to assess the draft strategy:

- The primary objective of all maternity services should be healthy mothers and babies.
- Ideology and practitioner-specific agendas should not determine maternity policies and services.
- Policies and services should be evidence-based.
- Policies and services should consider the woman, her baby, and family.
- Funding should follow models of care which improve the health and survival of mothers and babies, are cost effective, and improve women's experiences.

Research

BY CHRIS JOHNSON

Research into HIV stigma revealing

Australia marked World AIDS Day on Saturday December 1, just as new research was released to reveal the enduring challenge of tackling stigma surrounding HIV.

The *Stigma Indicators Monitoring Project: People living with HIV* by the UNSW Sydney Centre for Social Research in Health (CSRH) was jointly released with The Australian Federation of AIDS Organisation (AFAO).

The new research is part of an overall project tracking social stigma among populations including people living with HIV, men who have sex with men, injectable drug users and people who engage in sex work.

The results of the *Stigma Indicators Monitoring Project: People living with HIV* are based on a survey of 181 Australians living with HIV. Despite an increase in knowledge and education about HIV/AIDS, research found many people living with HIV/AIDS still face stigma in their day-to-day lives.

"One of the great successes of Australia's community-led HIV response has been the mobilisation of those most affected, to mount highly effective treatment and prevention programs," said Professor Carla Treloar, Director of the Centre for Social Research in Health.

"However, our research shows that we still have a long way to go before people living with HIV, sex workers, people who inject drugs, and men who have sex with men are free from the burden of stigma."

Key findings from *Stigma Indicators Monitoring Project: People living with HIV* include:

AMA Indigenous Medical Scholarship 2019

Applications are now being sought for the 2019 Australian Medical Association (AMA) Indigenous Medical Scholarship. Applicants must be of Aboriginal and/or Torres Strait Islander background.

Applicants must be currently enrolled full-time at an Australian medical school and at least in their first year of medicine. Preference will be given to applicants who do not already hold any other scholarship or bursary.

The Scholarship will be awarded on the recommendation of a selection panel appointed by the AMA. The value of the Scholarship for 2019 will be $10,000 per annum. This amount will be paid in a lump sum for each year of study.

The duration of the Scholarship will be for the full course of a medical degree, however this is subject to review.

Applications close 31 January 2019.

To receive further information on how to apply, please contact Sandra Riley, Administration Officer, AMA on (02) 6270 5400 or email indigenousscholarship@ama.com.au. An application package can be also downloaded from the AMA website www.ama.com.au/indigenous-medical-scholarship-2019.

The Indigenous Peoples' Medical Scholarship Trust Fund was established in 1994 with a contribution from the Australian Government. In 2016, the Trust Fund became The AMA Indigenous Medical Scholarship Foundation. The Foundation is administered by AMA Pty Ltd.

If you are interested in making a donation towards the Scholarship, please go to www.ama.com.au/donate-indigenous-medical-scholarship.

The AMA would like to acknowledge the contributions of the following donors: Reuben Pelerman Benevolent Foundation; the late Beryl Jamieson's wishes for donations towards the Indigenous Medical Scholarship; Deakin University; The Anna Wearne Fund and B B & A Miller Fund, sub-funds of the Australian Communities Foundation.

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- 74 per cent of participants surveyed have experienced stigma or discrimination in relation to their HIV status in the last year;
- 19 per cent of participants surveyed experienced stigma or discrimination 'rarely', 37 per cent experienced it 'sometimes', 11 per cent experienced it 'often' and seven per cent experienced it 'always'; and
- More than half of respondents living with HIV reported negative or different treatment by health workers (52 per cent). Most indicated this happened 'rarely' or 'sometimes' (44 per cent).

The UNSW research also shows the persistence of stigma toward people most likely to be exposed to HIV. In a parallel survey of 1000 members of the general public, 86 per cent indicated they would behave negatively toward people who inject drugs with 28 per cent indicating this would 'often' or 'always' be the case. The overall level of stigma toward sex workers was 64 per cent. And despite progress against homophobia, 38 per cent of participants said they would behave negatively toward someone based on sexual orientation.

Darryl O'Donnell, CEO of the Australian Federation of AIDS Organisations said: "Advances in medicine, technology and health promotion have powered strong progress against HIV. However, stigma is still with us and it presents a high barrier to HIV prevention.

"The sad truth is that many people do not get tested for HIV because of the stigma that surrounds it. There is a gulf between the modern reality of HIV as an entirely manageable condition and the way people perceive it.

"As we mark World AIDS Day we should challenge the stereotypes that hold back the HIV prevention effort. It's time to treat HIV as a disease like any other and dispense with judgemental tropes."

Fewer than five in 100 interventional cardiologists are women

A new study has highlighted a critical gender gap in interventional cardiology, the medical field specialising in treating blocked arteries in heart disease.

There are only 19 female interventional cardiologists in all of Australia and New Zealand – just 4.8 per cent of that workforce, a new study by medical researchers, including a UNSW PhD student, has shown.

In light of the findings, the researchers have called for change to increase much-needed diversity in the field – and to improve clinical care and outcomes for women. With cardiovascular disease the main cause of death for both men and women, the study is relevant to a large number of Australians.

The findings, published in the *Journal of the American College of Cardiology*, are the result of research performed by Women in Interventional Cardiology of Australian and New Zealand (WiiCAN – pronounced 'we can').

On top of the severe gender disparity in interventional cardiology, the data also reveal that only 15 per cent of all cardiologists across the two countries are women, that 73 per cent of public hospitals have no female interventional cardiologists at all, and that three Australian States have none either.

One of the lead authors, interventional cardiologist Dr Sonya Burgess, is working at Nepean Hospital in Sydney. She is also completing a doctorate at UNSW Sydney, studying patients with heart attacks and the importance of complete revascularisation of the coronary arteries for these patients. She says there are many barriers for female trainees.

"I started my cardiology training in 2007 in New Zealand, the country that first gave women the vote, yet also a country that now has had more female prime ministers than female interventional cardiologists," she said.

"The reasons for this are complex, but can be overcome with positive changes."

The paper discusses factors contributing to this gap, including the importance of role models, the expectations of training and society, the impact of geography, occupational radiation, cardiology's workplace culture, unconscious gender bias, and strategies for promoting change.

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The authors call for more evidence-based solutions to tackle the problem, including systematic approaches to actively address disparity and achieve more visibility, so trainees see female role models in leadership positions, in faculty at conferences and in training hospitals.

“We need leaders who believe the data is important and who value diversity, to allow us to change from a culture of de-facto exclusion to one of active inclusion,” Dr Burgess said.

“It is now well documented that women with heart disease receive less treatment, fewer appropriate medications, and experience higher mortality compared to men.

“At the same time, several studies have reported better clinical outcomes for patients treated by female cardiologists and physicians, notably including improved survival rates for female heart attack patients when treated by a female doctor.”

To help address some of these issues and create a community of women, Dr Burgess co-founded WiiCAN.

Dr Burgess helped found the social network in 2017, when she met the other two co-founders, Dr Sarah Zaman from Monash Medical Centre and Dr Elizabeth Shaw from Hornsby Ku-ring-gai Hospital, at a conference that brought together Australian and New Zealand interventional cardiologists. Their goal is to give a voice to female cardiology trainees, patients and colleagues, so they would not feel isolated in a male-dominated workforce.

BY CHRIS JOHNSON

Measles growing in some countries

Gaps in vaccination coverage have led to an increase in reported cases of measles around the world. In 2017, numerous countries experienced severe and protracted outbreaks of the disease.

Because of these immunisation gaps, measles outbreaks occurred in all regions, and there were an estimated 110,000 deaths related to the disease.

Updated disease modelling data provides the most comprehensive estimates of measles trends over the last 17 years. It shows that since 2,000, over 21 million lives have been saved through measles immunisations. However, reported cases increased by more than 30 percent worldwide from 2016.

The Americas, the Eastern Mediterranean Region, and Europe experienced the greatest upsurges in cases in 2017, with the Western Pacific the only World Health Organisation (WHO) region where measles incidence fell.

“The resurgence of measles is of serious concern, with extended outbreaks occurring across regions, and particularly in countries that had achieved, or were close to achieving measles elimination,” said Dr Soumya Swaminathan, Deputy Director General for Programs at WHO.

“Without urgent efforts to increase vaccination coverage and identify populations with unacceptable levels of under-immunised or unimmunised children, we risk losing decades of progress in protecting children and communities against this devastating, but entirely preventable disease.”

Measles is a serious and highly contagious disease. It can cause debilitating or fatal complications, including, severe diarrhoea and dehydration, pneumonia, ear infections and permanent vision loss. Babies and young children with malnutrition and weak immune systems are particularly vulnerable to complications and death.

The disease is preventable through two doses of a safe and effective vaccine. For several years, however, global coverage with the first dose of measles vaccine has stalled at 85 per cent. This is far short of the 95 per cent needed to prevent outbreaks, and leaves many people, in many communities, susceptible to the disease. Second dose coverage stands at 67 per cent.

“The increase in measles cases is deeply concerning, but not surprising,” said Dr Seth Berkley, CEO of Gavi, the Vaccine Alliance.

“Complacency about the disease and the spread of falsehoods about the vaccine in Europe, a collapsing health system in Venezuela and pockets of fragility and low immunisation coverage in Africa are combining to bring about a global resurgence of measles after years of progress. Existing strategies need to change: more effort needs to go into increasing routine immunisation coverage and strengthening health systems. Otherwise we will continue chasing one outbreak after another.”

Responding to the recent outbreaks, health agencies are calling for sustained investment in immunisation systems, alongside efforts to strengthen routine vaccination services. These efforts must focus especially on reaching the poorest, most marginalised communities, including people affected by conflict and displacement.

The agencies also call for actions to build broad-based public support for immunisations, while tackling misinformation and hesitancy around vaccines where these exist.

“Sustained investments are needed to strengthen immunization service delivery and to use every opportunity for delivering vaccines to those who need them,” said Dr Robert Linkins, Branch Chief of Accelerated Disease Control and Vaccine Preventable Disease Surveillance at the U.S. Centers for Disease Control and Prevention (CDC) and Measles and Rubella Initiative Management Team Chairman.

The Measles and Rubella Initiative is a partnership formed in 2001 of the American Red Cross, CDC, the United Nations Foundation, UNICEF, and WHO.

First ever multi-drug Ebola trial for the Congo

The Ministry of Health of the Democratic Republic of the Congo (DRC) has announced that a randomised control trial has begun to evaluate the effectiveness and safety of drugs used in the treatment of Ebola patients.

The trial is the first-ever multi drug trial for an Ebola treatment. It will form part of a multi-outbreak, multi-country study that was agreed to by partners under a World Health Organisation (WHO) initiative.

Until now, more than 160 patients have been treated with investigational therapeutics under an ethical framework developed by WHO, in consultation with experts in the field and the DRC, called the Monitored Emergency Use of Unregistered and Investigational Interventions (MEURI).

The MEURI protocol was not designed to evaluate the drugs. Now that protocols for trials are in place, patients will be offered treatments under that framework in the facilities where the trial has started. In others, compassionate use will continue up to the time when they join the randomisation. Patients will not be treated noticeably differently from before, though the treatment they receive will be decided by random allocation. The data gathered will become standardised and will be useful for drawing conclusions about the safety and efficacy of the drugs.

“Our country is struck with Ebola outbreaks too often, which also means we have unique expertise in combatting it,” said Dr Olly Ilunga, Minister of Health of the DRC.

“These trials will contribute to building that knowledge, while we continue to respond on every front to bring the current outbreak to an end.”

In October, WHO convened a meeting of international organisations, United Nations partners, countries at risk of Ebola, drug manufacturers and others to agree on a framework to continue trials in the next Ebola outbreak, whenever and wherever that is. Over time, this will lead to an accumulation of evidence that will help to draw robust conclusions across outbreaks about the currently available drugs, and any new ones that may come along.

At the heart of the long-term plan and the current trial is always the goal to ensure that patients with Ebola and their communities are treated with respect and fairness. All patients should be provided with the highest level of care and have access to the most promising medications.

The current trial is coordinated by WHO, and led and sponsored by the DRC’s National Institute for Biomedical Research (INRB), in partnership with the DRC Ministry of Health, the National Institute of Allergy and Infectious Diseases (NIAID) which is part of the United States’ National Institutes of Health, The Alliance for International Medical Action (ALIMA) and other organisations.

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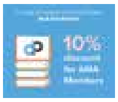

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