AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

What's in it for health?

Federal Election policy debate, p3

INSIDE

AMA

ISSUE 31.08 MAY 6 2019

AUSTRALIAN
Medicine

Managing Editor: John Flannery

Editor: Chris Johnson

Contributors: Maria Hawthorne
Virginia DeCourcy
Georgia Morris

Graphic Design: Streamline Creative, Canberra

Advertising enquiries

Streamline Creative
Tel: (02) 6260 5100

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

AMA LEADERSHIP TEAM

President
Dr Tony Bartone

Vice President
Dr Chris Zappala

In this issue

Cover pic: Shadow Health Minister Catherine King and Health Minister Greg Hunt shake hands before debating health policy at the National Press Club.

(Photo by Odette Visser)

Contenders debate health policy at press club

National Press Club debate on health policy.

AMA policy positions have been applauded by both major political parties, during a live broadcast of the Federal Election campaign's health debate at the National Press Club of Australia.

Health Minister Greg Hunt and Shadow Health Minister Catherine King each delivered their pitches and were in turn grilled by political journalists during the hour-long telecast from Canberra.

Mid-way through the campaign, health policy maintains a high priority of the election as the parties fight for the all-important health vote.

AMA President Dr Tony Bartone described the debate as informative and positive, with sound messages from each side – but with some glaring omissions on the policy front.

"It was a good strong debate, with lots of commitments to long-held AMA policy, and commitments to strongly resource these policies," Dr Bartone said.

"There was important attention to recognised medicines and to supporting general practice.

"And each party delivered anti-vaping messages, which is very important.

"However, there was no mention of aged care and still no great detail around mental health. We need them to connect the dots.

"The AMA will compare and contrast these policies and publicly rate them accordingly before election day.

"But we need to see the major parties announcing the missing pieces from their healthcare vision over the next two-and-a-half weeks.

"As the population ages and more people are living longer with multiple complex and chronic conditions, it is vital that Australia has a robust, connected, and holistic strategy to ensure improved health outcomes for patients throughout life.

"The Australian health system is one of the best in the world, if not the best. But it will take strong leadership, hard work, good policy with long-term strategic vision, and significant well-targeted funding to keep it working efficiently to meet growing community demand.

"The health system has many parts, and they are all linked. Governments cannot concentrate on a few, and neglect the others. Otherwise, patients will be the ultimate losers. Whole patient care cannot be done in silos, in parts, or in isolation."

Under questioning from the reporters in the room, Mr Hunt and

Contenders debate health policy at press club

...continued from p3

Dr Bartone with Catherine King.

Dr Bartone with Greg Hunt.

Ms King both described the uptake of vaping by teenagers in the United States as a "public health disaster" and said they would not support policies that could see Australia go down the same path.

This view is supported by the AMA.

Other health issues canvassed included out-of-pocket medical expenses, public hospital funding, cancer care, the Pharmaceutical Benefits Scheme, and primary care, with both sides detailing their spending commitments and obviously claiming superior healthcare visions for the nation.

On public hospitals, Ms King said Labor would invest an extra $2.8 billion and pointed to the AMA's own advocacy on the issue.

"Just two weeks ago the Australian Medical Association declared our hospitals are chronically under-funded, our doctors and nurses are at breaking point, and patients are waiting longer than ever before for emergency treatment and... surgery," she said.

"The AMA's *Public Hospital Report Card* was a damning indictment of the six years of cuts and chaos from the Liberals."

Ms King repeated Labor's proposal to spend $2.3 billion over four years to improve Medicare coverage of cancer services.

"This election offers a stark choice, and nowhere is that choice more stark than when it comes to health policy," she said.

"It's a choice between a Labor Party with an ambitious health agenda, and a Liberal Party with no agenda at all."

Mr Hunt said Labor had not "done the work" on its cancer plan and had offered Australians few details and incorrect costings on the plan.

Ms King rejected that statement.

But the Minister said he had a long-term vision for the nation's health, and repeated his four-pillar plan of primary health, hospitals, mental health and medical research

On Medicare and bulk-billing rates, Mr Hunt said the Coalition Government had a good record of increasing funding and rates since it has been in office.

"Looking forward ... what we are doing across all of the conditions in relation to diagnostic imaging, an investment of $600 million for new MRIs across the country," he said, while praising the work of the AMA in primary care initiatives.

"But perhaps most importantly, working the AMA and College of GPs transforming what we are doing in primary health care by giving older patients the capacity to have their doctor in the home," Mr Hunt said.

"Over the telephone, over teleconference, over the way they prescribe, through email and text – transforming access."

CHRIS JOHNSON

Election must result in better funding for public hospitals

Dr Bartone talking to Sky News about hospital funding.

The AMA has used the backdrop of the Federal Election campaign to release its *2019 Public Hospital Report Card* and call for greater funding for struggling hospitals.

The Report Card was released over the Easter long weekend and highlights the plight of many public hospitals having to deal with inadequate funding.

In releasing the document, AMA President Dr Tony Bartone said it demonstrated the need for the sector be better resourced, and he called on all major political parties to use the election campaign to promise significant new long-term funding.

He said whichever party forms government after the May 18 election, it should immediately fix the funding shortfall for the nation's public hospitals.

Dr Bartone said the Report Card painted a depressing picture of overstretched hospitals and patients waiting longer for their care.

The ability of the hospitals to cope with ever-increasing patient demand continues to decline, he said, and it is a trend that will only accelerate unless something is done.

Election must result in better funding for public hospitals

...continued from p5

"Public hospitals are a vital pillar of our world-class health system, but neglect and underfunding are dooming them to failure," Dr Bartone said.

"All our governments have to lift their game, but the leadership and the funding priorities and strategies must come from the Federal Government.

"Our public hospitals need clear and transparent long-term funding arrangements, above and beyond the current formulas."

Key findings of the Report Card include: static bed ratios for the general population and a 24-year low of hospital beds per 1000 people aged 65 years and older; longer waiting times for patients in emergency departments, with only 64 per cent of urgent presentations seen within the recommended 30-minute timeframe in 2017-18; nationally, more than a third of the almost three million patients who presented to an emergency department in need of urgent treatment waited longer than clinically recommended; and in three of the eight States and Territories, about one in five patients who need elective surgery within 90 days are waiting longer than clinically-recommended.

Emergency treatment times for 'urgent' patients have gone backwards in most States and Territories. None have performed substantially better than last year.

Elective surgery is not much better, with most jurisdictions performing worse or remaining static.

"Compared to last year, elective surgery admissions per 1,000 population actually went backwards by 1.5 per cent nationally, and backwards in every jurisdiction bar two," Dr Bartone said.

"No jurisdiction improved performance across all indicators in our Report Card. The picture should be one of continual improvement. Sadly, it is not.

"This is not what our rapidly growing and ageing population deserves. It is certainly not a base to provide the level and amount of care needed for the increasing complex conditions the community will face in coming years."

Dr Bartone said public hospitals were the first port of call for emergency care and intensive care. And they are the only place for the sickest of patients who arrive in an emergency who need intensive care or treatment for conditions such as life threatening burns or as a result of car accidents or falls.

But he said there were significant consequences of underfunding public hospitals.

"Every year, the Australian population gets older and sicker," Dr Bartone said

"It's no surprise then that public hospitals are treating more patients each year. Between 2012-13 and 2016-17, public hospital separations rose on average 4.5 per cent per annum.

"The number of emergency presentations also rose on average by 2.6 per cent each year over the same period.

"Across all types of public hospital service, the rate of increased demand is outstripping the 1.6 per cent, per annum, rate of population growth.

"Underfunding can lead to increased numbers of deaths for admitted patients, higher levels complications, delayed care, delayed pain relief, and longer length of stay for patients.

"Public hospital capacity is determined by funding. We can't have a hospital system that is stretched so tight that scheduled elective surgery is cancelled because ward beds are needed by seriously ill patients who unexpectedly present in emergency.

"We can't have a hospital system that is so under-resourced that primary health care doctors cannot find a hospital bed for their patients who need elective surgery.

"Greater funding is needed to lift the capacity of our hospitals.

"They need the resources to first slow the decline, before they can show significant performance improvements.

"Greater funding is needed to support the highly-skilled, dedicated, and hardworking doctors, nurses, other health professionals, and hospital workers who are asked to do more with less every day.

"And greater funding is needed to ensure that patients can get access to high-quality care when they need it, without long waiting times."

JOHN FLANNERY AND CHRIS JOHNSON

The 2019 AMA Public Hospital Report Card is available at https://ama.com.au/ama-public-hospital-report-card-2019

Labor's Indigenous health policy

Labor has released its Indigenous health policy, pledging $115 million towards tackling preventable diseases and youth suicides among Indigenous youth.

The plan also addresses rheumatic heart disease, sexual health, and eye diseases.

Announcing the policy in the Northern Territory a week into the Federal Election campaign, Opposition Leader Bill Shorten said improving the health status of First Australians is a critical component of Australia's journey towards reconciliation.

"Every Australian, Indigenous or non-Indigenous, should have access to the health services they need, where and when they need them," Mr Shorten said, adding that Indigenous Australians "have the right to grow old".

Included in the $115 million dollar commitment is $25m to address rheumatic heart disease, $16.5m to expand the Deadly Choices campaign, $20m for sexual health promotion, and $13m to help stop vision loss.

"Wholly preventable eye diseases and blindness should be unacceptable in a developed nation like Australia," the Opposition leader said.

AMA President Dr Tony Bartone welcome the commitments, describing them as a "good start to a much-needed, strongly-funded, long-term strategy to close the life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians".

Dr Bartone said Aboriginal and Torres Strait Islander people have the right to enjoy the same level of good health that is experienced by other Australians.

Key to achieving that goal is to provide culturally responsive services for Indigenous people, where and when they need them, he said.

Dr Bartone said Labor's plan recognises the expertise and unique experience of Aboriginal Community Controlled Health Services.

"The AMA wants to see funding for Aboriginal Community Controlled Health Services increased so they can continue to deliver sustainable, high-quality, comprehensive primary health care services to Aboriginal and Torres Strait Islander people and communities," he said.

The AMA has previously welcomed the Coalition's Budget commitments for Indigenous health, including $15 million for Indigenous suicide prevention and $20 million for Indigenous-specific initiatives such as the implementation of the national strategies for blood borne viruses and sexually transmissible infections.

The major parties have announced similar approaches to address Rheumatic Heart Disease (RHD).

CHRIS JOHNSON

The AMA's *Key Health Issues for the 2019 Federal Election* document is available at https://ama.com.au/article/key-health-issues-2019-federal-election

Cancer is the battleground

Cancer treatment is a key focal point of health policy promises of the Federal election campaign.

The Coalition has committed to making life-saving cancer medications more affordable, adding three new cancer medicines to the Pharmaceutical Benefits Scheme (PBS) in May this year.

This includes medications to treat advanced breast cancer and an aggressive skin cancer type.

Without the new subsidy, patients would have to fork out $55,000 a year for the breast cancer drug and $150,000 a year for the skin cancer medication.

The Coalition says 2,000 new and amended items have been added to the PBS under its watch since 2013, totalling $10.6 billion.

The recently handed down Budget allocated $331 million to subsidise expensive new drugs, and eight of them were cancer medications.

Labor ensured cancer treatment was a top priority by flagging a $2.3 billion cancer plan that promises cheaper cancer scans, cheaper cancer specialist consultations and cheaper cancer medicines.

The plan includes spending $433 million on 3 million free specialist consultations for people with cancer.

Labor's promise includes introducing a new Medicare item to cover the cost of a consultation with an oncologist or surgeon with a $150 rebate.

Specialists could only claim for these if they bulk-billed the sessions.

Labor says the extra Medicare item would see bulk-billing rates for specialists rise from about 40 to 80 per cent.

Opposition Leader Bill Shorten's line that cancer makes you sick but it shouldn't make you poor, is being repeated often by Labor candidates as the campaign continues.

CHRIS JOHNSON

AMA docs on the hustings

Two former Federal AMA Presidents are standing as candidates in the 2019 Federal election.

The first, Professor Kerryn Phelps, AMA President from 2000-2003, has already experienced the rough and tumble of politics in Canberra, having won the 2018 by-election to succeed former PM Malcolm Turnbull as the Member for Wentworth in Sydney's eastern suburbs.

In her six months as an MP, Kerryn, still a practising GP, has made quite an impact. She steered the highly debated Medevac Bill, also known as the Urgent Medical Treatment Bill, through the Parliament, and has been outspoken on issues such as renewable energy and climate change. Support for general practice is high on the Phelps policy agenda.

She has also been instrumental in uniting the Independent MPs and Senators in the Parliament to vote on key legislation, and more recently led calls for a royal commission into the water buyback scheme.

Describing herself as economically conservative and socially progressive, Prof Phelps – a Councillor on the City of Sydney Council since 2016, including a stint as Deputy Mayor – has moved seamlessly into the combative political environment in Canberra.

But commentators say she will have a battle to retain Wentworth – traditionally one of the safest Coalition seats in the country – at the May 18 election, when she will be up against the Liberals' Dave Sharma, whom she narrowly defeated in the by-election.

There are no signs of doubt in her campaign team, though. When *Australian Medicine* visited her campaign HQ in Edgecliff recently, a planning meeting was in progress.

Her team, which includes experienced political operatives from across the political spectrum and fresh-faced young volunteers alive with the buzz of being players in the political process, was discussing everything from policy development and media strategy down to who was going to do the early morning shifts

...continued from p8

handing out flyers at Bondi and Edgecliff railway stations.

The other big issue at the meeting was the spate of overnight thefts of Phelps corflutes across the electorate, including from iconic Bondi Beach, which had witnessed a political poster crime wave.

Some psephologists may have their doubts about Phelps being returned as the Member for Wentworth, but Team Phelps has no such doubts. The upbeat and optimistic purple T-shirt-wearing brigade are confident that Kerryn can overcome the odds for another unlikely win.

Meanwhile, across town in Bennelong – the seat that was home for many years to former PM John Howard, until he was unseated by Labor's Maxine McKew in 2007, who in turn was defeated by star Liberal candidate, tennis legend John Alexander, in 2010 – another former AMA President has chosen a difficult path to a political career.

Apart from McKew's one term as the local MP, Bennelong has been in Liberal Party hands since the 1950s.

But when he was announced as a Labor candidate in 2018, Professor Brian Owler, AMA President from 2014-16, made the decision to take on the tough challenge of once again winning Bennelong for Labor.

When *Australian Medicine* dropped in to visit Prof Owler, he had spent the day doorknocking in Ermington, in the west of an inner metropolitan electorate that also includes Epping, Gladesville, Meadowbank, and Ryde.

Owler – a neurosurgeon, face of the NSW Government's 'Don't Rush' road safety campaign, and prominent autism awareness campaigner – does not underestimate the challenge he has taken on. But he is putting everything into his campaign. He is serious about winning it.

Being the underdog candidate in a high-profile electorate is not a glamorous life. On his Facebook page, Brian can be seen doing the obligatory flyer handout and meet and greet with commuters at railway stations and bus stops, and attending the many and varied community events in this diverse electorate. Visibility is everything, especially for new political hopefuls up against high profile incumbents.

Doorknocking is another core activity for would-be MPs. Owler says that, no matter which way they vote, people are for the most part polite and attentive whenever he taps on their front doors.

He recounts that only one resident had proved argumentative, but in a civil way. An elderly chap felt the need to follow him down the street peppering him with questions about tax policy. They agreed to disagree.

Owler said that Labor's Medicare Cancer Plan is proving popular with voters.

"Everybody knows someone who has been affected by cancer in some way," he said.

Professor Owler's electorate office had not opened at the time of our visit, but was about a week away from establishing a presence at the Eastwood shops. He said that things would accelerate from there with more help from Labor HQ and having a local base for his growing team of volunteer supporters.

It is a big jump from medical politics to Federal politics, but both Owler and Phelps cite their experience as AMA NSW President and Federal AMA President as the spark that lit the political fire in their bellies.

And they both see health policy and health reform as critical factors in their respective quests to be elected to the House of Representatives. They both want to be advocates for change, just as they were in the top job at the AMA.

It is only a matter of weeks before we see if they can emulate the success of another former AMA President, Dr Brendan Nelson, who held the Sydney seat of Bradfield for the Liberals from 1996 to 2009. He served as Education Minister and Defence Minister, and was Opposition Leader from 2007-08.

Another former Federal AMA President, Dr Bill Glasson, ran for the LNP against Kevin Rudd, then in his second term as PM, in the Brisbane seat of Griffith in 2013.

Rudd won, but Glasson achieved a 5.5 per cent swing against Labor. After Rudd left Parliament, Glasson contested the 2014 Griffith by-election, but lost to Labor's Terri Butler.

Australian Medicine will report after the election if there are AMA doctors in the House.

JOHN FLANNERY

Greens offer plan for mental health services

The Australian Greens have unveiled a mental health policy aimed at ensuring mental health services become universally and accessible to all Australians.

The six-point plan includes making services effective, transparent and accessible; funding prevention and early intervention through $500 million in funding over the next decade; building a fully funded and adequately staffed NDIS and provide an additional $450 million for community psychosocial services; building mentally healthy workplaces through providing $604 million over the decade for mental health workplace interventions in smaller businesses and $50 million per year for three years for mental health interventions in larger businesses and expanding the existing Individual Placement and Support trial; increasing the numbers of peer workers by providing $166 million to fund a two-year national peer workforce trial with 1,000 places; and reducing mental health stigma through an anti-stigma campaign involving those with lived experience.

"Mental illness is one of the biggest challenges of the 21st century and access to treatments should be universal. People in our community should be able to get easy access to treatments in the same way they would for a broken leg or the flu," Greens spokesperson on mental health Senator Rachel Siewert said.

"There has been under-investment in the mental health sector by successive governments, which has resulted in the system failing to meet the needs of thousands of Australians...

"All health services should be evaluated and funding should be provided in a transparent way, which we are not seeing at the moment. It's not just a matter of throwing money at an issue, funding needs to be properly targeted and evaluated so there is transparency around who is getting funding and whether outcomes are being achieved."

CHRIS JOHNSON

AMA Election Campaign Kit for GPs

In a move to highlight the importance of GP-led primary health care as a priority health issue in the current Federal election, the AMA has supplied its GP members with resources to help them lobby their local election candidates at the grassroots level.

The AMA has put primary health care at the top of its election policy wish list, and is calling on the major parties to roll out further significant funding promises for general practice and Australia's hardworking GPs.

AMA President Dr Tony Bartone said general practice touches all parts of the health system.

"General practice is the glue that holds everything together. It is the lifeblood that keeps people moving and healthy on their journey through the system," he said.

"GPs help people navigate their way to the right care for them at the right time. GPs are with their patients throughout life. They must be supported in this vital role."

Dr Bartone said there are GPs in every electorate across the country and they are very effective at conveying health policy messages to their politicians and their communities.

"We are supplying them with tools to enable them to be even more effective in their advocacy," Dr Bartone said.

"We have prepared talking points, handouts, materials for local candidates, and letters to the editor to help explain the policies needed to support general practice, keep GPs working in local communities, and attract new GPs to areas that need them."

The AMA election policy priorities include:

- funding to support longer consultations with patients;
- improving access to after-hours GP services;
- funding MBS rebates for GP telehealth consultations;
- providing better wound care;
- enhancing access to GP-led team-based care via the Workforce Incentive Program;
- improving conditions for GP registrars; and
- funding for a dedicated GP mental health program.

Dr Bartone said the AMA welcomed the Coalition's Budget announcement of almost one billion dollars of investment in general practice as an important first step.

"There is much more to be done, and we will be urging all the major parties to release comprehensive general practice and primary care policies in the coming weeks."

The AMA Election Campaign Kit can be found at: https://ama.com.au/GP_Campaign_Kit

The AMA Indigenous Medical Scholarship - Donation Made Easy

The number of Aboriginal and Torres Strait Islander people attending university is sharply increasing; and more Indigenous people are choosing to study medicine.

There are now well over 200 Indigenous doctors practicing medicine across Australia, but barriers remain that prevent many Aboriginal and Torres Strait Islander people from completing a medical degree. Factors, such as cultural differences, racism, high expectations, financial hardship, and lack of academic support all play a role in preventing students from realising their dream of being a medical professional.

The AMA has a scheme in place to support more Indigenous students to pursue their dream of becoming a doctor – the *Indigenous Medical Scholarship*. Each year, the AMA offers a Scholarship to an eligible Aboriginal or Torres Strait Islander student, providing financial support for the full duration of a medical degree.

Since its inception in 1994, the *Indigenous Medical Scholarship* has helped more than 20 Indigenous men and women become doctors, many of whom may not have otherwise had the financial resources to study medicine. Despite this success, the AMA hopes to expand the number of Scholarships on offer each year to meet the increasing demand for the Indigenous Medical Scholarship. The number of applicants for the Indigenous Medical Scholarship is increasing each year, and we expect this this to increase even more in the future.

It can cost between $10,800 and $15,000 to attend one year of university to study medicine and students typically undertake four to six years to complete their degree to become a registered medical practitioner.

There is evidence that Aboriginal and Torres Strait Islander people have improved health outcomes when they are treated by Indigenous doctors and health professionals. Indigenous doctors have a unique ability to align their clinical and sociocultural skills to improve access to services, and provide culturally appropriate care for Aboriginal and Torres Strait Islander people. Yet, Aboriginal and Torres Strait Islander doctors comprise less than 1 per cent of the entire medical workforce.

The AMA is seeking contributions towards the *Indigenous Medical Scholarship* to increase our support for Indigenous medical students, and to help grow the Indigenous medical workforce. All contributions can be claimed as a tax deduction.

By supporting an Indigenous medical student throughout their medical training, you are positively contributing to improving health outcomes for Aboriginal and Torres Strait Islander people.

As a donor, you can now easily donate to the *Indigenous Medical Scholarship* by simply clicking on the following link: https://indigenousscholarship.ama.com.au, entering your details and making a credit card payment. No more forms, emails or phone calls!

Further information about the Indigenous Medical Scholarship can also be found online at: https://ama.com.au/advocacy/indigenous-peoples-medical-scholarship or my emailing indigenousscholarship@ama.com.au or phoning (02) 6270 5400.

The Scholarship was established in 1994 with a contribution from the Australian Government.

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

DONATE TO THE AMA'S INDIGNEOUS MEDICAL SCHOLARSHIP TODAY!

Updated guidelines on sexual boundaries

The AMA has updated it guidelines on maintaining sexual boundaries between doctors and patients, which now includes a section acknowledging that the power imbalance may lead patients to feel vulnerable and exposed.

The AMA's *Patient Examination Guidelines 2012* and the *Position Statement on Sexual Boundaries Between Doctors and Their Patients 2012* were recently updated as part of the AMA's routine, five-year policy review cycle.

As there was a fair amount of repetition between the two documents, they have now been combined into one – the *Guidelines for Maintaining Clear Sexual Boundaries Between Doctors and Patients and the Conduct of Patient Examinations 2019*.

The AMA's updated guidelines were written to be consistent with the Medical Board of Australia's *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship*, which was released in December last year.

In the AMA's new document, it clearly states that doctors have an ethical and legal duty to maintain appropriate professional boundaries with patients.

Essentially, professional boundaries define the limits of the therapeutic relationship between doctors and patients not only in terms of physical space but also social, emotional and psychological space.

"There is a potential power imbalance in the doctor-patient relationship. While doctors have the highly specialised knowledge and skills patients require to obtain good quality health care, patients may feel vulnerable or are potentially vulnerable and exposed due to the very personal and physical nature of the doctor-patient relationship," the Guidelines state.

"For example, patients who seek care may be sick, injured, anxious and distressed. Further, they may be asked to undergo a physical examination which may cause discomfort and embarrassment or be asked to provide very personal and sensitive information about their health and lifestyle or relevant information about their family members.

"Because of the power-imbalance in the doctor-patient relationship, it is essential that doctors adhere to very strict professional boundaries to ensure that patients feel confident and safe when seeking medical care. Maintaining appropriate professional boundaries facilitates trust in the medical profession, promotes patient care and protects both doctors and patients.

"In order to maintain professional boundaries, a doctor should not use their professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with patients or those close to patients such as their carers, guardians or close family members including spouses or parents of a child patient.

"Violating professional boundaries undermines the doctor-patient relationship and may cause psychological harm to patients and compromise their medical care. In addition, such violations undermine the trust the community has in the profession to act with professionalism at all times, may constitute criminal conduct and may be subject to police investigation as well as disciplinary action."

The Guidelines also point out that doctors should be aware that professional boundaries apply not only to face-to-face patient consultations but also in the use of social media and other forms of electronic communication and consultation such as emails, text messages and telehealth.

And the Guidelines clearly state that a doctor must not engage, or seek to engage, in sexual activity with a current patient.

"This extends to behaviours of a sexual nature such as making sexual remarks, flirtatious behaviour, touching patients in a sexual way or engage in sexual behaviour in front of a patient as well as conducting a physical examination that is not clinically indicated or in the absence of patient consent," the document states.

Specifically on examinations, the Guidelines state that it is essential for a doctor to gain consent from the patient and explain why it may be necessary.

"A doctor should not conduct an examination if the patient does not consent or the consent is uncertain (there may be an exception in emergency circumstances). Where the patient does not consent or the consent is uncertain, the doctor should reiterate the importance of the examination with the patient," the Guidelines state.

"If practical, and with the patient's consent, the doctor may offer the patient an observer or support person to be present during the examination. If the patient continues to refuse to consent to the examination, the doctor should defer the examination or refer the patient to another doctor.

"The patient's refusal to undertake the examination should be recorded in the medical record along with any relevant discussion between doctor and patient. The doctor should record the recommended course of action; for example, defer the examination to another time, engage an observer or support person to be present during the examination or refer the patient to another doctor.

"If an examination is in progress and the patient withdraws consent, the doctor should cease the examination immediately. The doctor may wish to explore why consent has been withdrawn, defer the examination or refer the patient to another doctor. The patient's withdrawal of consent should be recorded in the medical record along with any relevant discussion between doctor and patient. The doctor should record the recommended course of action."

CHRIS JOHNSON

The full *Guidelines for Maintaining Clear Sexual Boundaries Between Doctors and Patients and the Conduct of Patient Examinations 2019* can be accessed at: https://ama.com.au/position-statement/maintaining-clear-sexual-boundaries-between-doctors-and-patients-and-conduct

LETTER TO MEMBERS FROM THE PRESIDENT

MBS Review Consultation – Specialist and Consultant Physicians

Dear Colleague,

As you well know, the Government and the Department of Health have been leading the Review of the Medicare Benefits Schedule (MBS) now for almost four years, with over 80 clinical committees and working groups reviewing all 5,700 items - the majority of which have not been reviewed in decades.

The MBS Review Taskforce has released 55 Clinical Committee reports to date, and the AMA has been active in calling for the review to be a fair and transparent process - not simply a savings exercise. The AMA has been working behind the scenes, and sometimes in a more visible fashion, with craft groups, our members and the broader medical profession to provide responses to these reports.

It is in that vein I wish to draw your attention to one key MBS Review report, released in February. It is the report from the **Specialist and Consultant Physicians Consultation Clinical Committee** - available at (http://www.health.gov.au/internet/main/publishing.nsf/Content/mbs-review-2018-taskforce-reports-cp/$File/SCPCCC%20Report.pdf).

This report proposes major reforms, cutting across all specialties, as it recommends a comprehensive restructure of specialist and consultant physician attendance items. The Report proposes a move away from initial and subsequent consultations, differential rebates for specialists and consultant physicians and additional payments for complex planning, to a time-based structure similar to that applied in general practice.

Other recommendations are no less significant and include:

- Removing current telehealth loading and complex care plan items and a move to time tiering
- A new framework for case conferences
- National minimum data set to inform patients of:
  + Clinical practice variation between institutions and individual provider
  + Providers' out of pocket fees (*shared via patient's GP*)
  + Providers' clinical outcomes data (*shared via patient's GP*)
- Use of item descriptors & CPD education to improve informed financial consent
- My Health Record incentive payments to increase uptake and use

These recommendations have the potential to impact not just specialists and consultant physicians, but also their patients.

The AMA has had the opportunity to attend one consultation with the MBS Taskforce and key craft groups regarding this report, but it was clear the message about this report must be spread further.

The report will require a response from all concerned clinicians. Please feel free to respond directly to the Department, here. I also implore you to bring this report to the attention of your relevant College, Association and Society. Such critical proposed reforms need all voices to be heard. As always, please feel free to provide your feedback to the AMA, as well your craft group.

In the meantime the AMA will continue to advocate for greater time to be given to the profession to respond to such a far reaching report.

Kind Regards,

Tony Bartone
President

Australia moving to international dysphagia diet terminology

The International Dysphagia Diets Standardisation Initiative (IDDSI) Framework uses standardised terminology, labelling and testing methods to improve safety and reduce choking and aspiration risks for people with dysphagia (see Figure 1). The new IDDSI Framework came into effect in Australia on May 1, 2019. The implementation is supported by the Australian IDDSI Steering Committee that includes representatives from Speech Pathology Australia, the Dietitians Association of Australia, the Institute of Hospitality in HealthCare, IDDSI international and industry.

Dysphagia is listed by the World Health Organisation in both the International Classification of Diseases (ICD-10) and the International Classification of Functioning Disability and Health. Dysphagia can occur at any time during the lifespan, may be short or long term and conservatively affects about eight per cent of the population. The most common causes of dysphagia are related to underlying medical or physical conditions such as prematurity of birth, cerebral palsy, head injury, cancer of the head and neck, stroke, dementia, psychological or psychiatric conditions and other conditions. Dysphagia affects 30 to 50 per cent of residents in aged care facilities. Although choking risk is well recognised in young people, it less well known that the incidence of choking on food is seven times greater for people over the age of 65 years than it is in children aged 1 to 4 years[1].

To reduce choking risk foods may be pureed, minced or chopped, and drinks may be thickened. The NSW Ombudsman's report into Reviewable deaths of people with Disability in Residential Care (2012-2013 and 2014-2017), recommends that to reduce preventable deaths there must be improvement in identification and management of swallowing and choking risks, and better communication about food textures that are safe for people with dysphagia to eat. The term 'soft diet' in particular has caused confusion amongst health and care workers and has resulted in choking deaths across Australia[2].

The Australian Standardised Terminology for Texture Modified Foods and Fluids were introduced on a voluntary basis in 2007. Until the development of the IDDSI Framework in 2015 some countries used national terminologies, while others had no national strategy. As such, texture modified foods or thick drinks could be called and labelled at one level in Australia and quite differently in other countries. The adoption of international

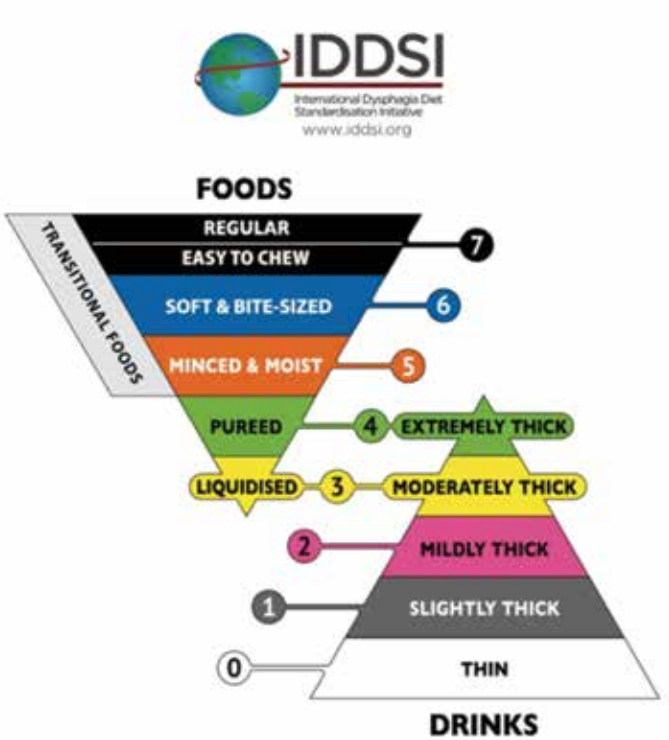


Figure 1: The IDDSI Framework

standards supports person-centred risk management of dysphagia, and provides a common language for technical, cultural, professional and non-professional uses. As with adoption of the Australian Terminology in 2007, transition to the IDDSI Framework is also voluntary. Many hospitals, health care professionals, aged care organisations, disability providers, community groups and industry are in the process of getting ready to move to IDDSI from May 1, 2019.

Major changes from the Australian terminology to the IDDSI framework include a new numbering system, colour code changes denoting the thickness of drinks (see Figure 2), and the removal of bread and sandwiches from the new IDDSI Level 6 Soft & Bite-Sized (Australian Texture A Soft). This follows the international standard not to include bread and sandwiches on

...continued from p14

the Level 6 Soft & Bite sized diet as it poses an extremely high choking risk based on summaries from international coronial inquests and autopsy data, and reports such as the NSW Ombudsman's 2012-2013 report (See Figure 3)[2,3,4].

For more information about IDDSI, to download consumer handouts or learn more about the initiative visit the IDDSI website (https://iddsi.org/) or contact the Australian IDDSI Project Office Dr Julie Cichero at austarlia@iddsi.org.

DR JULIE CICHERO (PHD)
ON BEHALF OF THE AUSTRALIAN IDDSI STEERING COMMITTEE

References:

1. Kramarow et al. (2014). Food related choking deaths among the elderly, *Injury Prevention* http://dx.doi.org/10.1136/injuryprev-2013-040795

2. NSW Ombudsman (2015). *Report of Reviewable Deaths in 2012 and 2013. Volume 2: Deaths of people with disability in residential care*. Crown Copyright, NSW Ombudsman

3. Berzlanovich, et al. (2005). Foreign body asphyxia: A preventable cause of death in the elderly. *Americal Journal of Preventative Medicine*, 28: 65–69, doi:10.1016/j.ampere.2004.04.002.

4. NSW Ombudsman (2018). *Report of Reviewable Deaths in 2014 and 2015; 2016 and 2017.: Deaths of people with disability in residential care*. New South Wales, NSW Ombudsman.

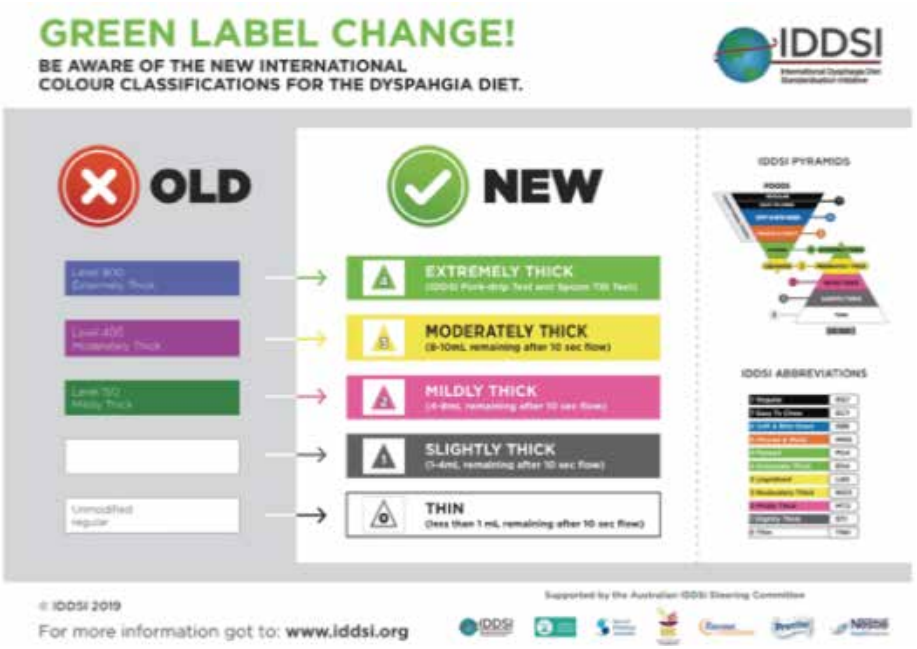


Figure 2: Changes to numbering and colour codes denoting drink thickness

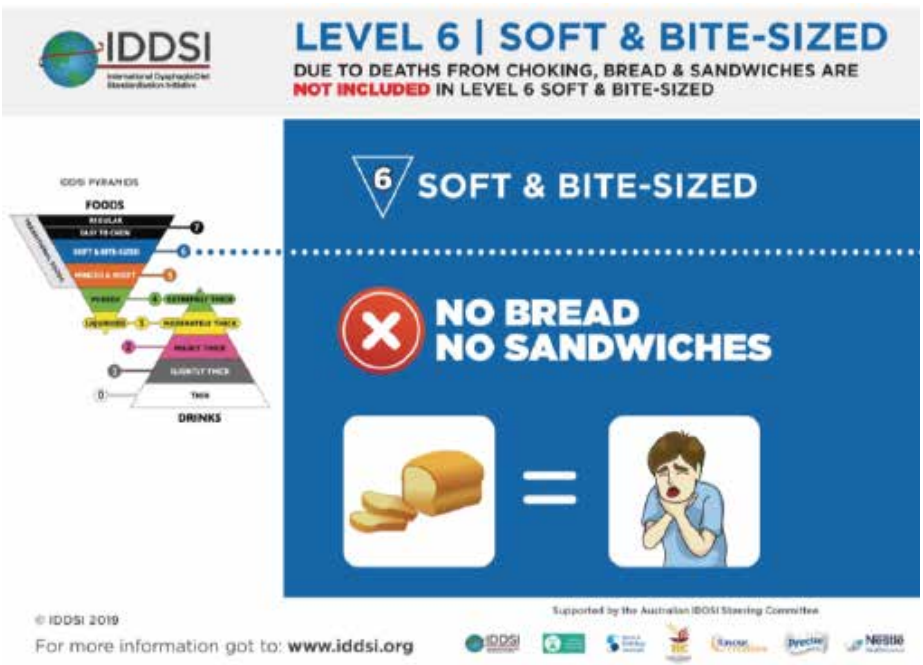


Figure 3: No bread or sandwiches on Level 6 Soft & Bite-Sized due to increased choking risk

Your food – the Health Star Rating system five years on

BY PROFESSOR GEOFFREY J DOBB – AMA REPRESENTATIVE ON HEALTH STAR RATING ADVISORY COMMITTEE

You, like nearly all Australians, will be aware of the Health Star Rating (HSR) graphic that has appeared on the front labels of more than 13,000 processed and packaged foods since it was introduced. The AMA was present at both its conception and birth, and has generally supported the HSR system as it approaches its fifth birthday.

An AMA campaign to introduce front of package labelling using a 'traffic light' system was vigorously opposed by the food and grocery industry but resulted in a Working Group with public health, consumer, industry and government representatives that was excellently chaired by Ms Jane Halton, then Secretary at the Department of Health. The outcome was consensus support for the voluntary HSR system as a mean of providing summary information for consumers on the nutrient value of their purchases.

The calculator used to allocate the HSR is publicly available on the HSR website. In short, negative points for nutrients such as sugar, salt and saturated fat can be offset by positive points for fruit, vegetable, nut, legume and protein content. This highly nutrient focussed approach has been criticised by some, and has produced outcomes that may have surprised. Nevertheless, it is transparent to both consumers and industry, so encouraging reformulation to increase the HSR by reducing sugar content for example.

Some of the most controversial anomalies have been addressed by ensuring that the HSR is calculated on the content of the product 'as sold' except for the addition or drainage of water, rather than 'as prepared' with the addition of variable ingredients.

The HSR was conceived for and applied only to packaged and processed foods. The ratings are intended for comparisons within product lines; that is, to compare between breakfast cereals or between dairy products such as flavoured milks, for example. It was not originally intended to apply to fresh fruit and vegetables, though it can be argued that a five-star processed food should not be perceived as better nutrition than the fresh stuff. Also, the HSR is not a panacea for Australia's obesity epidemic, though it can help consumers choose products in the supermarket.

In recent years there has been a relative lack of public health advertising that could encourage compliance with the Australian Dietary Guidelines, smaller serving sizes and regular exercise – these too will be important if we are to reduce over-weight and obesity. Because it is nutrient based the HSR does not consider if there are benefits from products that are 'organic' or 'bio-dynamic' despite advocacy that such products are inherently 'healthier'. Claims for 'organic' content can be made elsewhere on the packaging.

Surveys have shown that 83 per cent of Australian consumers are aware of the HSR system with 75 per cent finding it easy to use and half reporting that it influenced their purchasing decisions. On the down side, many products still do not display the HSR and there is some evidence of bias towards displaying the HSR on products with more stars and not on those scoring poorly.

From the outset, it was intended that The HSR would be thoroughly reviewed as it reaches five years. A review prepared by independent consultants will go to the relevant State and Commonwealth Ministers in the second half of 2019. It is likely that changes will be proposed to the HSR calculator to further penalise high sugar and salt content and make some adjustment within product lines. Whether the HSR is applied to fresh fruit and vegetables remains to be seen.

However, changes are likely to apply to only a small minority of all the grocery products sold. Overall, it has been a success to which the AMA has contributed. Consumer recognition is high and uptake by the supermarkets' own brands in particular has also been high. Participation by industry in the voluntary HSR system can and should be higher, but the AMA looks forward to the final report of the five-year review and the response by State and Commonwealth Ministers to its recommendations.

Electric vehicles, good policy when it comes to health?

If you've been reading the news of late, you will have noticed a considerable uptake in attention surrounding electric vehicles, particularly from politicians. Loud noises on the topic, from both sides of politics, dominated the news for the first week of April. Is the attention warranted? Photo ops aside, will electric vehicles have significant impacts for health?

On April 1, in front of a shiny charging station in the centre of Canberra, the ALP announced its climate policy – including its plan to increase electric vehicle use. Labor's proposal aims to ensure that 50 per cent of new car sales are electric vehicles (EVs) by 2030, and that 50 per cent of the government car fleet are EVs by 2025. The policy also includes tax incentives for businesses purchasing EVs and proposed emissions standards for all light vehicles – limiting emissions to 105 grams of CO2 per kilometre, on average.

Despite their protestations and assurances that Bill Shorten is 'coming for your weekend', the Coalition's proposed climate solutions package also includes provisions for electric vehicles. It has promised a national electric vehicle strategy. Environment Department officials conceded in Senate Estimates that EV use would likely rise to between 25 per cent and 50 per cent of new cars under the Government's plan. The Coalition Government also announced $6m of funding for a rapid charging network in 2018. Requisite shouting about the superiority of each party's policy has ensued.

With all this rhetoric, important points about the impact of transport emissions on health are being missed. The Australian Institute of Health and Welfare estimates that about 3,000 deaths per year in Australia can be attributed to urban air pollution. Air pollution directly contributes to mortality and ill-health from stroke, heart disease, lung disease and lung cancer, and has also been linked to asthma, diabetes and high blood pressure.

Transport emissions, which largely result from burning fuel in internal combustion engines, are particularly associated with harmful pollutants such as particulate matter, carbon monoxide and nitrous oxides. Overall, transport is the second highest contributor to emissions in Australia, comprising 19 per cent of total emissions. However, this contribution is more pronounced in urban centres. For example, in both Sydney and Melbourne, motor vehicle emissions are responsible for the majority of air pollution, and this has significant costs for health. Researchers have estimated that motor vehicle emissions caused 1715 deaths in Australia in 2015 – a higher amount than the 2015 national road toll.

Current policies aren't improving the situation. Australia's cars emit 45 per cent more pollution than the OECD average, and Australia is ranked 22nd of 23 high-emitting countries on

transport energy efficiency. In 2018, 0.2 per cent of new cars sold in Australia were EVs, compared to a whopping 58.4 per cent in Norway. Australian transport emissions are on the rise – they have increased by 60 per cent since 1990 and are expected to increase a further 15 per cent by 2030.

Electric vehicles have been heralded as a solution to the transport emissions problem. According to the Climate Council, when totally powered by renewable energy, EV emissions can be as low as six grams of CO2 per km, compared to 184g/km for average new cars. But importantly, emissions from EVs vary depending on the energy source used to recharge them. Based on current power grid formulations, an EV powered on the Queensland grid would have emissions 25 per cent lower than a vehicle with a combustion engine, while an EV charged on Victoria's brown-coal reliant grid would have higher emissions than an average new car.

Unless EVs are powered by renewable sources, all they represent is a shift in air pollution locations from congested urban roads, to electricity plants located in suburban and regional areas. EVs will have the most impact in grids powered by renewables.

Overall, the EV story is an optimistic one. The final report of the Senate Inquiry into Electric Vehicles, released in January, found that transitioning to EVs would have more benefits than challenges, bringing economic, environmental and health advantages. Modelling by PwC estimates that a utilisation of EVs at 57 per cent of new cars by 2030 would reduce emissions by 18 million tonnes annually. If ambitious policies to encourage uptake are pursued by whichever party forms the next government, we might all enjoy the weekend fresh air in our electric utes for decades to come.

VIRGINIA DeCOURCY

AMA PUBLIC HEALTH POLICY ADVISER

AMA

National Conference

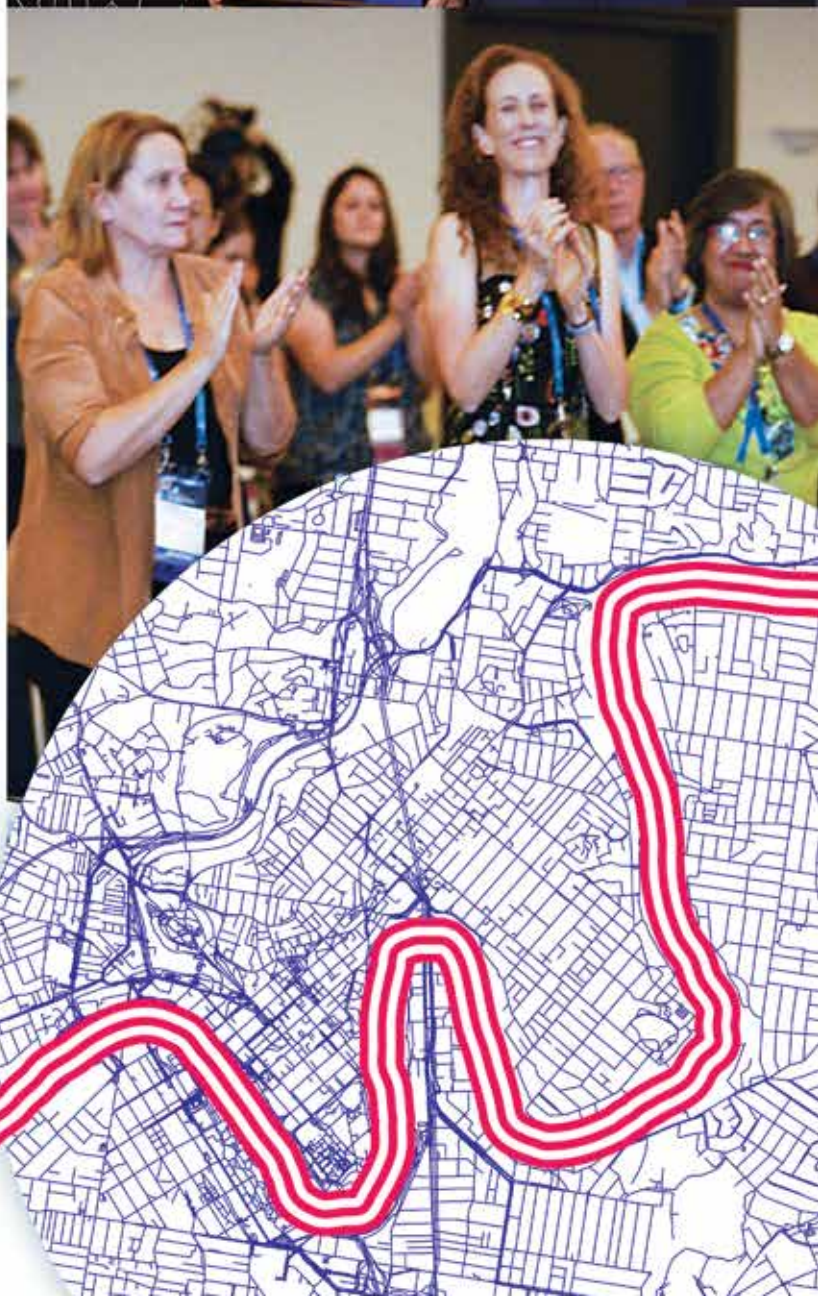
Sofitel Brisbane

24-26 MAY 2019

Hear the latest developments and debate contemporary health issues, from aged care to artificial intelligence, mental health, workforce challenges and more.

Open to students, junior doctors and medical professionals.

Visit natcon.ama.com.au
for more information and to register



#AMANATCON

NATCON.AMA.COM.AU

ACCC takes Bupa to court

The Australian Competition and Consumer Commission is taking Bupa to court for allegedly making false and misleading claims about the services it provides at some of its aged care facilities.

At more than a quarter of its aged care homes (21 of 78), Bupa is alleged to have charged residents thousands of dollars more a year for extra services it did not provide.

The rorting is alleged to have continued for more than a decade, from December 2007 to June 2018.

Bupa allegedly charged clients for services that were either not provided at all or not fully provided.

"In some cases, the alleged misleading representations related to services that were significant to the quality of life of elderly residents," ACCC chair Rod Sims said.

"The promised services were likely also what attracted many residents and their families to choose Bupa."

Some of the promised services that were not provided include fully equipped physiotherapy rooms, air-conditioning in bedrooms, covered outdoor exercise areas, separate leisure activity spaces, hot breakfasts, sensory walkways, talking book libraries, travel escorts for outside appointments, and smart-room technology systems for dementia residents.

The ACCC case against Bupa relate to 11 homes in NSW, seven in Victoria, two in Queensland and one in Tasmania.

An internal Bupa investigation has been conducted and about 550 residents have been repaid with interest.

Bupa's aged care managing director Jan Adams apologised to residents and families in a statement.

"We are committed to addressing this to put things right," Ms Adams said.

"We have made significant changes to our systems to ensure this does not happen again."

CHRIS JOHNSON

Proton pump inhibitors move to 'Authority Required'

From May 1, doctors prescribing proton pump inhibitors (PPIs) for their patients under the PBS will need to take additional steps, following changes to the PBS restriction criteria to comply with clinical guidelines. High dose PPIs are now Authority Required (Telephone) and standard dose PPIs are now Authority Required (Streamlined).

Information about the reason for the changes is available on the PBS website at <http://www.pbs.gov.au/info/news/2019/05/changes-to-proton-pump-inhibitor-restriction-level>.

For Authority Required (Telephone) listings, the doctors must write the item on an authority prescription form and gain prior authority approval from the Department of Human Services for PBS subsidisation. Doctors can either:

- call the PBS authority approval telephone line on 1800 888 333 for authority requests; or
- request electronic PBS authority approval through the Online PBS Authorities system via HPOS.

For further information and a step-by-step guide for requesting an online PBS authority read more at: https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/hpos/services/request-authority-using-online-pbs-authorities-hpos

For Authority Required (Streamlined) listings, prescribers must write the item on an authority prescription form and must endorse the prescription with the valid streamlined code. To prepare for new and amended PBS listings prescribers must ensure their prescribing software is up-to-date.

The Department of Human Services has advised that PBS prescriptions written prior to May 1, 2019 for PPIs will still be valid for PBS subsidy for the life of the prescription.

Codeine over-the-counter dispensing decision vindicated

The decision to ban over-the-counter sales of codeine has been vindicated by figures showing that the amount of potentially addictive and harmful codeine products dispensed to Australians halved in 2018, AMA President Dr Tony Bartone has said.

The Therapeutic Goods Administration (TGA) up-scheduled codeine to prescription-only in February 2018, following evidence that alternative over-the-counter painkillers were just as effective for short-term pain as low-dose codeine products, but without the codeine-related health risks.

The TGA has now released an analysis of pharmaceutical industry sales data, which found that 17.1 million packs of codeine-containing products were sold in 2018, about 50 per cent lower than the yearly average of 34.7 million for the previous four years.

The 2018 figure includes one month of sales (January 2018) before the up-scheduling came into effect, so still includes some data for over-the-counter sales.

Dr Bartone said the decision to ban over-the-counter sales was made to protect Australians from a commonly-misused medicine.

"The evidence shows that low-dose codeine provides little benefit beyond placebo for short-term pain, and it is not a safe treatment for long-term or chronic pain," Dr Bartone said.

"Studies showed that thousands of Australians were using codeine inappropriately and putting themselves at risk of addiction, organ damage, and other health problems.

"The AMA strongly supported the decision by the TGA, as the independent regulator, to act in the interests of patient safety, and up-schedule codeine products.

"The TGA and the Federal Government held firm in the face of great pressure from the pharmacy lobby groups, particularly the Pharmacy Guild of Australia, which launched a prolonged and very strong multi-State offensive against this change.

"The pharmacy lobby also claimed that up-scheduling would lead to doctor-shopping, and patients switching from low-dose to high-dose codeine medicines.

"However, the TGA analysis shows that the increase in the supply of high-strength 30mg codeine between February and December 2018 was not statistically significant.

"These reforms have always been about reducing the level of codeine in the community, not about switching the source of the supply of codeine.

"The AMA has actively advocated for many years for the introduction of a genuine, national Real Time Prescription Monitoring system that tracks all prescribing and dispensing, is nationally consistent, and is interoperable with prescribing doctor software systems.

"This continues to be a very important area of AMA advocacy."

MARIA HAWTHORNE

The AMA *Position Statement on Medicines* is available at: https://ama.com.au/position-statement/medicines-2014

Doctor stood down over offensive online presence

A Melbourne doctor who called online for women to be raped has been stood down from the hospital he works for pending an investigation into his behaviour.

This follows a six-week suspension order imposed by a Tasmanian jurisdiction, which was widely condemned as insufficient.

The Tasmanian Health Practitioners Tribunal ordered Christopher Kwan Chen Lee, 31, be suspended for six weeks over "numerous inappropriate and offensive comments" he made on a Singaporean online forum in 2016.

At the time the posts were made, Dr Lee was a registrar at the Royal Hobart Hospital, but he has been an emergency registrar in Victoria since 2018. The suspension, however, bars him from working anywhere in Australia.

Amid an outcry that the penalty was too light, Eastern Health, the health district in Victoria responsible for the Box Hill Hospital where Dr Lee is currently employed, began its own investigation into the implications of the Tasmanian tribunal's finings.

While the initial suspension was not set to begin until some weeks after the decision was made, Eastern Health has stood Dr Lee down immediately.

"Dr Lee will not be returning to work until the completion of this investigation," Eastern Health said in a statement.

"We wish to advise that Eastern Health takes the issue of professional misconduct very seriously.

"We value diversity, inclusivity and living together respectfully and do not tolerate disrespectful comments or racism in any form."

The AMA has condemned Dr Lee's actions, saying attitudes that condone violence against women "have no place in the medical profession"

Dr Chris Moy, Chair of the AMA's Ethics and Medico-legal Committee said the same level of behaviour and the same respect for dignity of patients and the community must be maintained on social media.

"I'm upset that this has occurred. Doctors should clearly be above this," Dr Moy said.

Photo from Facebook account

"The ability to stay above this sort of behaviour has to be at the forefront of doctors' minds when they act, especially when they interact with the community."

AMA Victoria President, Associate Professor Julian Rait said: "Attitudes that condone racism or promote violence against women really have no place in the medical profession."

Dr Lee, who is from Malaysia but studied medicine in Melbourne, has regularly commented from Australia to an online forum based in Singapore. He has used the forum to make numerous offensive remarks, including "some women deserve to be raped" and "she needs to be abandoned in India and repeatedly raped in order for her to wake up her idea" and "don't bother helping that nation of ingrates" (in reference to the tsunami that hit Indonesia last September.

He has reportedly also posted naked photos on the internet of a woman who criticised him online.

He has boasted about his sex life and said of his wife "If my marriage fell apart, it would not end in divorce. It would end in murder."

An online petition, started by sexual assault service Laurel House, is calling for Dr Lee's licence to practice medicine to be revoked.

CHRIS JOHNSON

Doctors beyond our own borders

REFLECTIONS ON MY JOURNEY INTO GLOBAL HEALTH

BY MARYAM SOOMRO

In early 2018, I travelled to Pakistan to visit my relatives for the first time as a medical student. In a country with a vibrant and welcoming culture, I found that the news of my career choice spread quickly. In no time, I was invited to attend, observe and participate in a number of learning opportunities under the guidance of my aunt, a GP who mentored me through a new medical culture and my first encounter with global health.

Of the many differences I saw in medical practice, the commonalities that struck me most was that the ideological approaches to health are shared by healthcare providers worldwide however the challenges we face differ from country to country, creating a subculture in each country's healthcare system. The time I spent in Pakistan became my stepping stone into the world of global health.

My initial impression of Pakistani healthcare providers was that their emphasis on patient histories and examinations

...continued from p22

and in-depth understanding of infectious diseases was more pronounced than I had previously encountered in my rotations in Victoria, yet it seemed to stem from the seemingly universal healthcare ideologies we all share.

The way medicine is practised in Pakistan follows a similar model of patient-centred care that we have in Australia; however, given the challenges faced by the general population, it manifests in an entirely different way. Patients there face poverty, a lack of public health awareness and inaccessibility to health care, due to both distance and cost. I soon understood that many investigations bore out-of-pocket costs that patients in Pakistan often could not afford; as such, doctors honed their history-taking and examination skills to perfection.

From GPs who analysed the individual aspects of the JVP waveform to formulate a differentials list, to interns who performed ascitic taps without ultrasound guidance, watching doctors practice medicine without resources was a humbling and awe-inspiring experience. I also saw doctors addressing the rising challenge of bacteria that was resistant to a multitude of antibiotics – a challenge that our public health system is soon likely to face. I find I am eager to learn more from my overseas colleagues and share what knowledge I have learnt from my mentors here in Australia. The colleges seem to be amenable to this, with RACP, RANZCOG, and ACEM all offering accredited supervised overseas rotations.

My first global health venture was a very holistic one; alongside gaining knowledge and experience in different medical settings, I gained greater appreciation of the history and culture of the region. From trekking the Himalayas to yoga at the beaches of Karachi, I found myself in a country of stark beauty and immense history. Buildings from the Mughal era rubbed shoulders with their British colonial counterparts, and Buddhists poured into Taxila to recount the Buddha's steps, while the Sikh pilgrims came to Lahore to visit the birthplace of Guru Nanak.

By culturally enriching myself in this way, I found that on returning to Australia, I can now build rapport with patients from the subcontinent about several aspects of their cultural backgrounds, from poetry to food to their opinions on Ayurvedic herbal remedies. Learning from a hospital outside of Melbourne had the added adventure of cafés and brunch spots being replaced by chaiwallahs and hawkers selling samosas, parathas, and all manners of meat on skewers and curry. Breaks between lectures for me soon became a (very cheap) culinary affair. I found myself living and learning medicine, food, culture, philosophy and art, with subtleties revealed beyond the confines of tourism in the humdrum of every day life.

One of the greatest gifts I brought back from my global health journey is one that I only appreciate just now in my current elective rotation, namely the understanding of the nuances of culture, and how it influences the patient-doctor relationship. Despite my own experiences growing up in a Pakistani family, I had never really realised what a Pakistani patient-doctor relationship looked like until I had entered that setting as a healthcare provider.

The relationship does not just involve the doctor and the patient but also their family, which is often just as, if not more, invested in the health of the patient as the patient themselves. In one case I recall a young patient with renal failure whose older sister had attended a GP appointment instead of him to discuss the implications of renal failure – he had been too busy attending a wedding to attend his appointment.

I found that I had grown in my understanding of collectivist cultures and the way they shape decision-making, a soft skill that is not covered by most medical schools in Australia yet is vital in bridging the gap for our migrant and Aboriginal communities. I now look forward to my next overseas placement, not just for the sake of travelling, but also for the opportunity to learn more about the backgrounds of my migrant patients and the practice of medicine by my colleagues across the world.

Since my venture into Pakistan, I have completed rural rotations and rotations with an Aboriginal health focus. My current rotation will involve me in refugee health here in Victoria. As I grow in my skills and capacity as a doctor, I cannot help but reflect on how a global health perspective has molded my abilities and pushed me beyond my comfort zone, at times even allowing me to meet my patients in theirs. I find myself wondering where my passion in global health will take me and what it will teach me. For all I know I could be doing obstetrics next to the pyramids, psychiatry in the Pyrenees mountains or paediatrics in the Amazon.

** Maryam Soomro is a member of the Australian Medical Students' Association*

Queensland sets dangerous precedent with pharmacy prescribing

The AMA is warning that the Queensland Government has set a very dangerous precedent by allowing pharmacists to dispense the contraceptive pill, as well as antibiotics for urinary tract infections, without a current prescription.

AMA President Dr Tony Bartone said the move undermines the importance of continuity of care and threatens the health of patients.

"No other State or Territory in Australia allows these medicines to be prescribed by pharmacists," Dr Bartone said.

"Medicines are poisons. They are highly regulated by Australian governments under 'poisons' legislation because they are fundamentally dangerous.

"Until now, all State and Territory governments have complied with the recommendations of the independent Therapeutic Goods Administration (TGA) about whether a doctor or a pharmacist or other health practitioner has the expertise to safely prescribe a specific medicine.

"The TGA has categorised the oral contraceptive pill and antibiotics for urinary tract infections as 'schedule 4 medicines', which means they can only be safely prescribed with the advice of a doctor.

"Pharmacists do not have the medical training required to determine the various complex factors involved in ensuring patient safety when it comes to prescribing a schedule 4 medicine. Simply prescribing the medicine, without holistic care and continuity of care, is dangerous."

Queensland Health Minister Steven Miles, announced on April 16 that Queensland Health would launch a State-wide trial allowing pharmacists to provide the contraceptive pill and antibiotics without a prescription.

The announcement followed determined lobbying by the Pharmacy Guild of Australia, representing pharmacy business owners.

Dr Bartone said even if a woman has previously been prescribed an oral contraceptive, it may not continue to be the most appropriate contraceptive.

"There may be other factors relating to a woman's health that have changed from her last prescription that can impact on which type of oral contraceptive is prescribed, or even whether an oral contraceptive is the most appropriate form of contraceptive. Seeing the doctor provides the opportunity for holistic, preventive patient care," Dr Bartone said.

"And unfettered prescribing of antibiotics by pharmacists to treat a urinary tract infection, without any clinical diagnosis, flies in the face of responsible antibiotic stewardship.

"With this trial, the Queensland government is encouraging potentially unnecessary use of antibiotics and the increase of antimicrobial resistance in our community. This is a global crisis with the emergence of 'superbug' epidemics.

"This is occurring while the Federal Government is trying to address antimicrobial resistance with a new committee working with GPs to reduce antibiotic prescribing.

"All governments should be working together to fight the threat of antibiotic resistance, rather than increase it."

Dr Bartone said the AMA fully supports pharmacists working collaboratively with doctors to provide health care for patients.

"Pharmacists are expert in medication management and education, and in dispensing low risk, non-prescription medicines," Dr Bartone said.

"The AMA supports non-medical health practitioners, including pharmacists, prescribing in a medically-led and delegated team environment.

"But pharmacists working within a retail pharmacy environment should never prescribe. Pharmacists deriving an income from medicines they prescribe represents a fundamental conflict of interest.

"Doctors derive no income or any other benefit from prescribing medicines. The separation of prescribing and dispensing is critical for patient safety.

"The Queensland model is a fundamental corruption of a safety check that has stood the test of time. There must be a separation between prescribing by a doctor, who prescribes with no financial or other benefit, and the dispensing of that medication by a pharmacist, who is solely responsible for checking the dosage and frequency.

"The Queensland approach means that retail pharmacists, receiving a financial benefit from every prescription, will now have a licence to do both, which potentially puts patients at risk.

"It is extremely worrying that the Queensland approach will see pharmacists prescribing independently, with no consultation with the patient's doctor.

"Multiple prescribers caring for a patient, independent of each other, is just bad health care."

JOHN FLANNERY AND GEORGIA MORRIS

Research

BY CHRIS JOHNSON

Smoke signals working in more teens

A study by James Cook University researchers has found that teen smokers are still deterred by graphic warnings on cigarette packets – even as the impact is starting to wear off on older people.

Led by PhD candidate and lecturer Aaron Drovandi, the study suggests that it is particularly important for teenagers to be discouraged from smoking, as most adult smokers started during their teenage years and find it harder to quit once addicted as adults.

"We found that graphic warnings and plain packaging increased adolescent awareness of the dangers of tobacco use, though there was significant variation amongst adolescents into the type of warning that they responded to best," Mr Drovandi said.

"Smoking still kills about seven million people a year. It's still incredibly dangerous and nicotine addiction during the formative years is linked to more significant risks to long-term health, productivity, and life expectancy."

The researchers analysed data from previous studies involving nearly 16,000 people around the world aged between 11 and 19, which measured the impact of cigarette packet warnings. No review had previously focused on the effects of these kinds of interventions on adolescents.

Graphic warnings depicting lung cancer, oral diseases and foetal damage were perceived as particularly effective on teens, but warnings about impotence and skin ageing made less of an impact.

Teens also took more notice when graphic images of the external effects on real people were used in the warnings.

"Plain packaging also reduced the attractiveness of cigarette packaging, with darker colours found to be the most effective," Mr Drovandi said.

"It also increased the visibility of the health warnings. People saw the cigarettes involved as having more tar content and having more serious health risks, and they had increased thoughts about quitting."

Several other studies by Mr Drovandi involving more than 2,000 participants found older smokers were beginning to ignore warning messages on their cigarette packets.

"Even though people were still looking at the pictures and messages, it was not affecting their behaviour. They felt that portraying the negative health consequences of smoking had been overdone," he said.

The studies also found that younger people, including school and university students, who had had less frequent exposure to tobacco packaging than older adults were not as jaded by it.

"Ideally, no-one would smoke. However, teenagers are a vulnerable population and the most valuable property for tobacco manufacturers," Mr Drovandi said.

"Further research is needed into the most effective warnings to use in combination with plain packaging to curb tobacco use among adolescents, and stop their exploitation by the tobacco industry."

Research

Surveys show lack of awareness re macular disease

More than 60 per cent of Australians are unaware of the strong familial risks associated with Australia's leading cause of blindness, putting their direct family members at risk of vision loss.

Macular Disease Foundation Australia (MDFA) Patron Ita Buttrose AO OBE, said people with siblings or parents with age-related macular degeneration (AMD) are in a high-risk category and have a 50 per cent chance of getting the disease.

"The best defence against vision loss from AMD are awareness and early detection," Ms Buttrose said.

To coincide with Macula Month, which runs throughout May, MDFA commissioned two YouGov Galaxy surveys targeting both the general population and Australians with AMD. They showed that:

- 63 per cent of the general population don't know there's a familial risk associated with AMD;
- Among Australians diagnosed with AMD, only half (50.1 per cent) are aware of the hereditary connection – of those, many dramatically underestimate the risk;
- Of the people who do understand the familial connection, almost one third (29 per cent) have not told all relevant family members they may be at risk themselves; and
- Only one in three (33.2 per cent) of those with AMD recalled being informed about the potential familial risk by their eye health professional.

AMD – a painless, progressive eye disease that destroys central vision – is the most common macular disease, accounting for 50 per cent of all cases of blindness and severe vision loss in Australia.

One in seven Australians over the age of 50 – almost 1.3 million people – already have some evidence of AMD.

There is no cure for AMD but there is effective sight-saving treatment for one form of the disease (wet or neovascular AMD) if detected early. As well, a macular-friendly diet and lifestyle changes, such as regular exercise and quitting smoking, are proven to delay onset and progression of AMD.

"From my experience as MDFA Patron, I know that people living with macular disease are extraordinarily stoic. They know their sight loss places a burden on their loved ones. I suspect many people with AMD don't talk about the risk because they don't want the people they love to worry," Ms Buttrose said.

"But we must start talking about how this disease can run in families. My father had AMD. Two of his siblings were diagnosed with it. I'm at risk, which is why I am proactive about my eye health."

Looking at qualified privilege legislation

A Monash University study suggests that a review of qualified privilege legislation may be warranted to maintain the balance between doctors' professional interests and the public interest.

In a perspective paper published recently the *Medical Journal of Australia*, the authors wrote that since 1992 qualified privilege legislation in Australia has allowed health professionals to have "open and frank discussions ... participating in the peer review of clinical cases".

Lead author Associate Professor Susannah Ahern, Head of the Registry Science and Research Unit at Monash, said that while patient health-related datasets are protected by national and State-based privacy laws that safeguard identified patient

Research

information, these data may be accessed by third parties in accordance with the law.

This could be by statutory bodies such as the Australian Health Practitioner Regulatory Agency, or by jurisdictional health complaints commissions, and in medico-legal proceedings.

The Bawa-Garba case in the United Kingdom has put qualified privilege in the spotlight. Dr Bawa-Garba was a paediatrics registrar who was struck off the medical register following the death of a six-year-old boy with Down Syndrome who was under her care in the Emergency Department of Leicester Royal Infirmary. She has recently been reinstated.

"While Bawa-Garba's personal reflection regarding the death ... documented as part of her training requirement by the Royal College of Physicians, was not made available in court, it has raised the issue of statutory protection of such documentation," Professor Ahern and her co-authors wrote.

"In Australia, the Royal Australasian College of Physicians Professional Qualities Reflection is currently covered by qualified privilege and offers reassurance that Australian physician trainees' personal reflections that may contain identified patient information are not accessible for disclosure by third parties.

"Nevertheless, case law in Australia and the UK still allows confidentiality (as a matter of common law), alongside privacy (the overarching Privacy Act 1988 and State, Territory or other information privacy statutes) to be overridden in the public interest.

"The role of qualified privilege at all levels warrants review, particularly for national qualified assurance and improvement activities. In particular, there should be an opportunity to consider whether the bodies that auspice large qualified improvement activities should have the ability to report or disclose information relating to clinician performance of substantial concern.

"The roles of various bodies in such a reporting process need to be determined. Ensuring an appropriate balance between these potentially competing professional and public interests through the further development and consideration of such models is critical and in the best interests of the medical profession and the broader community."

Latest figures raise awareness of heart disease factors

Newly released data reveal more than two thirds of Australian adults have at least three risk factors for heart disease.

At 69.1 per cent, that amounts to almost 13 million people at risk of the nation's biggest killer.

The data from the *Australian Bureau of Statistics National Health Survey 2017-18* was released by the Heart Foundation to mark Heart Week (28 April to 4 May 2019).

The Heart Foundations is using the data to urge GPs to deliver Medicare-funded Heart Health Checks, the patient-friendly term for an absolute cardiovascular disease (CVD) risk assessment.

Item 699 is newly available on the Medicare Benefits Schedule (MBS) and aims to support health professionals to give patients absolute CVD risk assessments.

It is eligible for All adults not already known to have CVD who are aged 45 years and above (30 years and above for Aboriginal and Torres Strait Islander peoples).

The item can be claimed once per patient in a 12-month period.

Professional attendance for a heart health assessment by a GP at consulting rooms lasting at least 20 minutes and must include:

Research

(a) collection of relevant information, including taking a patient history that is aimed at identifying CVD risk factors, including diabetes status, alcohol intake, smoking status, cholesterol status (if not performed within the last 12 months) and blood glucose;

(b) a physical examination, which must include recording of blood pressure;

(c) initiating interventions and referrals to address the identified risk factors;

(d) implementing a management plan for appropriate treatment of identified risk factors; and

(e) providing the patient with preventative health care advice and information, including modifiable lifestyle factors.

Heart Foundation chief medical adviser Professor Garry Jennings said existing items had not adequately addressed guideline assessment and ongoing management of patients with CVD risk factors.

"The new item number emphasises, for the first time, the clinical importance of CVD assessment," Professor Jennings said.

"We know that assessing and managing absolute CVD risk has the potential to prevent twice as many deaths from coronary heart disease when compared to treating individual risk factors."

Absolute CVD risk looks at the combined risk of multiple CVD risk factors to estimate the likelihood of a heart attack or stroke in the next five years. It involves recording a patient's physical or lifestyle-related CVD risk factors, measuring their risk using a validated calculator and providing ongoing care and advice regarding modifiable risk factors such as nutrition, exercise and weight control.

"Although we have come a long way from treating single risk factors for CVD, there is more work to be done to address the significant under-treatment gap in Australia," Professor Jennings said.

Up to 70 per cent of high-risk Australians aged 45 to 74 are not receiving guideline-recommended blood-pressure and lipid-lowering therapy.

"Importantly, assessing a patient's absolute CVD risk helps guide medical decision-making around who is likely to benefit most from medication, and who may not.

"The new interim Heart Health Check MBS item offers health professionals in primary care the chance to systematically assess and manage absolute CVD risk in an ongoing way."

It is estimated that widespread take-up of Heart Health Checks to people at high absolute risk of a CVD event could prevent 76,500 CVD events over the following five years.

Statins still good practice for high cholesterol

A new narrative review has shown that statins and other lipid-modifying therapies lower cardiovascular disease risk in patients with lipid abnormalities, such as raised levels of low-density lipoprotein (LDL) cholesterol (LDL-C).

The review, first published online by the *Medical Journal of Australia*, was conducted by Associate Professor Leon Simons, Director of the Lipid Research Department at the University of New South Wales, and St Vincent's Hospital, Sydney, and used original studies and review articles from 2005 to 2018 as well as specialist society publications, guidelines and conference proceedings.

"Lipid interventions with statins (ie, HMG-CoA reductase inhibitors, such as simvastatin, pravastatin, lovastatin, fluvastatin, pitavastatin, atorvastatin and rosuvastatin) lower cardiovascular risk," Professor Simons wrote.

Research

"Ezetimibe may be used as a supplement to statin therapy, or used alone in cases of statin intolerance. There exist statin-associated side effects, in particular muscle symptoms and new onset diabetes, which require careful management.

"Inhibitors of PCSK9 reduce LDL-C and cardiovascular risk. Evolocumab is subsidised in Australia for patients with familial hypercholesterolaemia where LDL-C is not adequately controlled with maximum doses of statin or ezetimibe, or when statin therapy is contraindicated.

"Lipid interventions to reduce triglycerides with fenofibrate lower cardiovascular risk in type 2 diabetes when triglycerides are elevated and high-density lipoprotein is low.

"All cases of secondary prevention need intensive lipid therapy, unless a contraindication exists. Lipid therapy is justified in cases of primary prevention at high absolute risk, when lipids are highly elevated or when multiple risk factors are present."

The author concludes that there is an "ongoing problem of poor long-term persistence on lipid therapy, as well as reduced awareness by practitioners of poor risk factor control".

Study of pregnancy vaccination rates

Women born overseas, those who smoked during pregnancy and Aboriginal and Torres Strait Islander women were less likely to be vaccinated against influenza during their pregnancies, according to recent research.

Published by the *Medical Journal of Australia*, the retrospective analysis of data from 153,980 pregnancies which ended in live birth or stillbirth between July 2015 and June 2017, found that, overall, 39 per cent of pregnant women were vaccinated against influenza.

Coverage varied by pregnancy end date, rising for influenza during winter and spring, but rising continuously across the two years for pertussis from 37.5 per cent to 82.2 per cent.

"Factors associated with vaccination included greater maternal age, primigravidity, early antenatal care, and GP-led care," wrote the authors, led by Ms Stacey Rowe, Principal Epidemiologist at the Department of Health and Human Services, and a PhD

candidate at Monash University.

Influenza and pertussis vaccinations during pregnancy are safe and effectively prevent infections in women and their infants, the authors wrote.

"The low and variable uptake of the influenza vaccine may reflect reduced awareness about the seriousness of influenza infection during pregnancy and early infancy," they said.

"It may also reflect seasonal availability of the vaccine or a misunderstanding about the recommendations for the administration of this vaccine: while vaccination is optimally received before the onset of influenza season, it can be given at any stage of pregnancy.

"Pregnant women are generally more concerned about health risks to their infants than to themselves; and, as women see pertussis as a greater risk for their babies, they are more likely to accept pertussis vaccination than influenza vaccination.

"Maternal vaccination remains the most effective strategy for preventing influenza and pertussis in pregnant women and their infants, and embedding its delivery into antenatal care pathways should be a priority."

World News

BY CHRIS JOHNSON

The World Medical Association held its 153rd Council session in the last week of April.

The gathering, attended by AMA President Dr Tony Bartone (who can be found in this accompanying group photograph – hint, he's on the left), was held in Santiago, Chile.

Following are some of the resolutions to have come out of the WMA Council session.

Do not implement IAAF regulations on classifying women athletes

The World Medical Association has called on physicians around the world to take no part in implementing new eligibility regulations for classifying female athletes.

The regulations from the International Association of Athletics Federations (IAAF) require women athletes with specific differences in sex development to medically reduce their natural blood testosterone level if they wish to continue racing as women in a few restricted events.

The Differences of Sexual Development (DSD) rule, introduced last year, followed the case of South African runner Caster Semenya, the world and Olympic champion, who has had to undergo gender verification testing to confirm her eligibility to compete in the women's division.

At its Council meeting in Santiago, Chile, the WMA demanded the immediate withdrawal of the regulations. It said they constitute a flagrant discrimination based on the genetic variation of female athletes and are contrary to international medical ethics and human rights standards.

Following an initiative by the South African Medical Association, the WMA fears the regulations would constrain the athletes concerned to take unjustified medication, not based on medical need, in order for them to be allowed to compete, and accordingly require physicians to prescribe such medication.

It is in general considered as unethical for physicians to prescribe treatment for excessive endogenous testosterone if the condition is not recognized as pathological. The WMA calls on physicians to oppose and refuse to perform any test or administer any treatment or medicine which is not in accordance with medical ethics, and which might be harmful to the athlete using it, especially to artificially modifying blood constituents, biochemistry or endogenous testosterone.

WMA President Dr. Leonid Eidelman said: "We have strong reservations about the ethical validity of these regulations.

World News

They are based on weak evidence from a single study, which is currently being widely debated by the scientific community. They are also contrary to a number of key WMA ethical statements and declarations, and as such we are calling for their immediate withdrawal."

World shortage of health professionals

Governments around the world have been urged by the World Medical Association to address the predicted global shortage of 18 million health professionals by presenting concrete plans for investing in the health workforce.

At its meeting in Santiago, Chile the WMA agreed a proposal for consideration at the High-Level United Nations Assembly meeting in September calling for governments to submit policies and financial commitments to meet the workforce shortage. In addition, the WMA wants to ensure safe and dignified working environments, where staff can thrive without fear of violence or coercion.

The September meeting in New York will be the first one-day UN High-Level Meeting on universal health coverage on the theme of 'Moving together to build a healthier world'. A preparatory multi-stakeholder hearing has been held to find a political consensus to draft a declaration at the September meeting setting out government commitments.

The WMA proposal document says that closing the health workforce gap is essential to achieving universal health coverage.

It reads: "Today, there are 76 countries with less than one physician per thousand people and three billion people without access to a health professional. It is unacceptable that the patient with cancer in Sierra Leone cannot get the care they need because there is no oncologist in the country or that the woman with obstetric fistula has to suffer because there is no gynaecologist."

WMA Chair Dr. Frank Montgomery said: "As our evidence to the High Level Meeting of the United Nations makes clear we strongly support the global move towards universal health coverage. This is high quality health care accessible for everyone at the time of need and without any financial barrier. This will not be achievable at once and everywhere, but nothing less should be the aim.

"As doctors, we took an oath to make our patients our first priority, and we believe that everyone should have access to high quality services without fear of financial hardship.

"Primary health care is a tool to further universal health care and the entry point into the health care system should be primary health care within a physician-led system. However, physicians are engaging alongside other health professionals to help make universal health care a reality for patients. Health care should be delivered in a multi-disciplinary health care team."

Warning on vaccine hesitancy

The World Medical Association has expressed its alarm about increasing reports of measles outbreaks in many parts of the world.

At its Council meeting in Santiago, Chile, the Association said that misconceptions about vaccinations and reduced vaccination rates posed a significant challenge for health authorities of all nations.

An emergency resolution agreed by the meeting said it was clear that increasing global travel by 'less than appropriately protected individuals' as well as misconceptions posed a challenge.

The resolution strongly reaffirms the WMA's 2012 Statement on the Prioritisation of Immunisation, denouncing unfounded and inaccurate claims about the possible dangers of vaccine administration.

Dr. Frank Montgomery, Chair of the WMA, said: "The growing measles outbreaks are putting both children and adult lives at risk. We echo the warning from the World Health Organisation that 'vaccine hesitancy' has become a top global health threat.

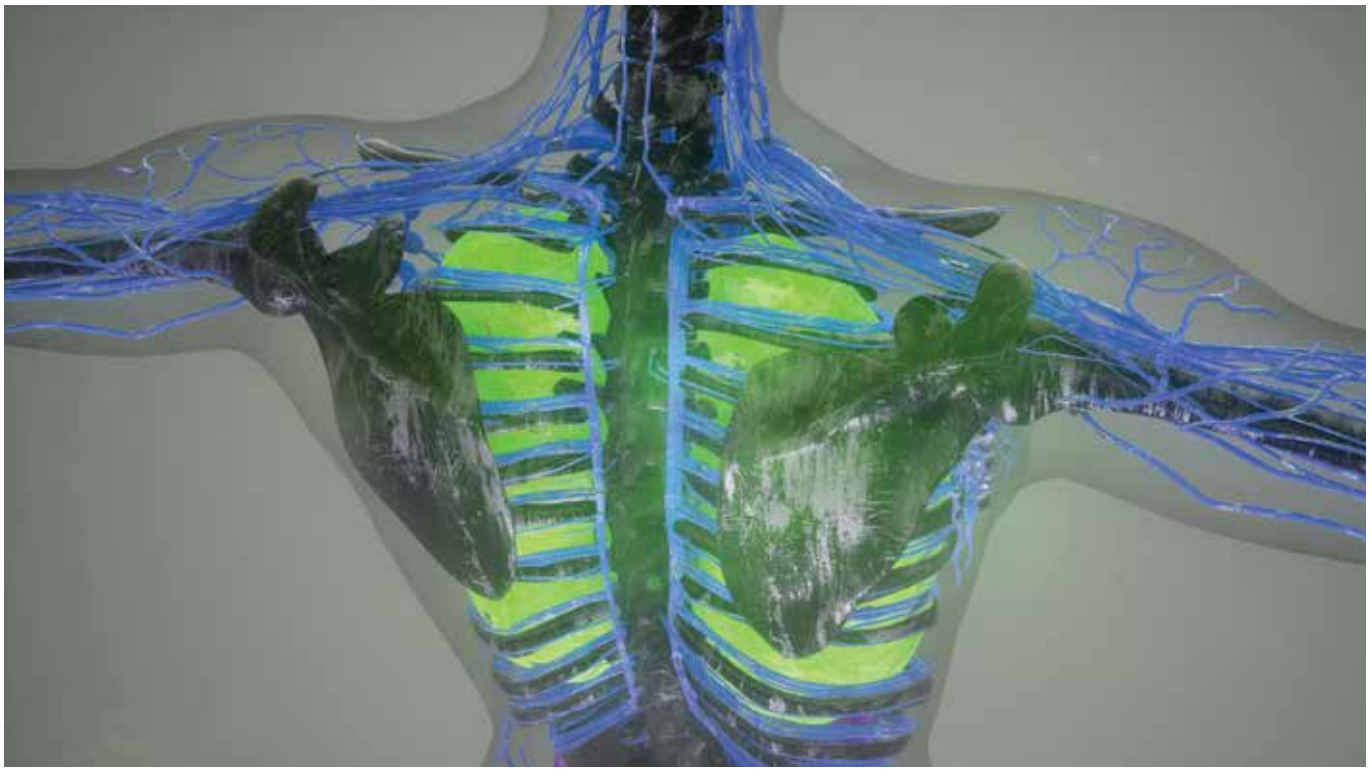
"Measles is not a trivial disease and vaccination should be regarded as a public duty and not an individual choice. The risk to herd immunity from vaccine hesitancy based on false data must be confronted."

WMA policy clearly states that vaccination and immunisation have been acknowledged as an effective and safe preventive strategy for several communicable diseases. And vaccine development and administration have been the most significant intervention to eradicate infectious diseases and influence global health in modern times.

The WMA is renewing its call to all its national medical association members to increase awareness of immunisation schedules and for individual physicians to pay special attention to addressing the concerns of vaccine hesitant parents.

World News

Non-smoking lung cancer on the rise in Britain



One in six people in the UK who are dying of lung cancer are non-smokers, with the causes being put down to growing levels of indoor and outdoor pollution.

Experts in lung cancer have revealed that a growing number of non-smokers across Britain are being diagnosed with the disease.

Many of these patients are being diagnosed at an incurable stage of the disease.

Rising car fumes, secondhand smoke, and both indoor and outdoor air pollution are being blamed.

Health authorities are now urging people to stop using wood-burning stoves because the of the carcinogenic properties of the soot they generate.

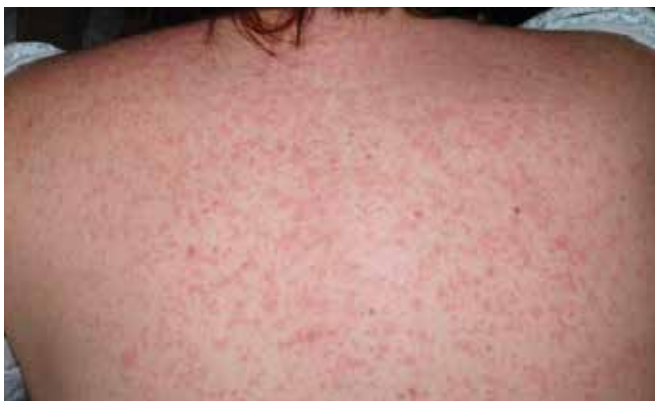
According to research recently published in the *Journal of the Royal Society of Medicine*, about 6,000 non-smoking Britons a year now die of lung cancer, which is about one-sixth of the 36,000 deaths from lung cancer each year.

That is more than those who die of ovarian or cervical cancer or leukaemia.

"If considered as a separate entity, lung cancer in never-smokers is the eighth most common cause of cancer-related death in the UK and the seventh most prevalent cancer in the world," the researchers state.

World News

Measles outbreak sends almost one thousand home from uni in LA



Los Angeles is getting tough on measles and ramping up its efforts to contain the spread of the disease in the face of a growing number of cases and continued resistance by some people to get vaccinated.

More than 900 students and staff at two LA universities were recently quarantined on campus or sent home as public health authorities take decisive action as measles cases reach a 25-year high in the United States.

The University of University of California, Los Angeles, and California State University, Los Angeles together have more than 65,000 students, and together they took serious action to reflect the graveness of the outbreak.

Officials later reported that two days after Los Angeles County ordered the precautions, about 200 of those affected had been cleared to return. But first they had to prove their immunity to measles, either through medical records or tests.

Others who remained under quarantine were told to stay at home and avoid contact with others.

“Measles actually kills people,” said Dr Armand Dorian, Chief Medical Officer at USC Verdugo Hills Hospital.

“So we have to take that really seriously.”

The number of measles cases in the U.S. has climbed to nearly 700 this year, including five in Los Angeles County and 38 across the State of California.

The outbreak is blamed largely on parents not getting their children vaccinated against the disease.

Polio immuniser killed in Pakistan

A polio worker has been shot dead in Pakistan amid rising violent conflicts over the vaccination program in the country.

Two female vaccination workers were attacked in the city of Chaman, which borders Afghanistan, as they carried out their work on April 25.

Nasreen Bibi, 35, was killed instantly, while another woman, 24, was critically injured.

At the time of publication the attackers were still at large, and authorities had temporarily shut down the anti-polio program for fear of further violence.

It is the third immunisation related death in a week, following the shooting of two police officers in separate incidents who were guarding vaccinators inoculating children in Pakistan’s Buner and Lahore districts.

Vaccination workers have received continued threats from Islamist militants who claim the immunisation push is a foreign scheme to sterilise children in Pakistan.

Pakistan, Afghanistan and Nigeria are only three countries in the world to have failed to eradicate polio.

Perfect setting, perfect festival

BY CHRIS JOHNSON

Morning yoga. Ocean views. Live classical music.

That's not a bad way to start any day, let alone Easter Sunday as part of the Four Winds music festival in Bermagui on the NSW South Coast.

The pain of yoga positions for a newbie like me is much easier to take with the tranquil sounds of a quartet in the corner of the Bermagui Surf Lifesaving Club overlooking a beautiful beach.

But morning yoga was just one small component of the very special event that is Four Winds.

Centred around the impressive Sound Shell and its natural amphitheatre in a stunning open forest setting a few kilometres south of town, Four Winds also showcases performances in the purpose-built Windsong Pavilion on the same site, as well as concerts in the town park, in local cafes, homes, and of course the surf club.

Getting to them all would completely fill your Easter weekend.

Selectively tasting a bit of each genre and venue was the way to go. Enjoying the music, but also enjoying the beach and the bush and the local cafes. It pretty much ads up to a perfect long weekend.

And while it is predominantly a classical music festival, there was ample jazz, world and folk music to also be enjoyed.

Star performers included the incredible soprano Dame Emma Kirby, classical accordionist (and the festival's artistic director) James Crabb, Bobby Singh on tabla and Sarangan Sriranganatha on sitar, pianist Stefan Vladar and the Festival Orchestra, Enigma Quartet, Arcadia Winds, Australian String Quartet, and more.

Genre-bending folk outfit Malumba rocked the surf club on Sunday night.

The festival has been going for 28 years and this was my first encounter with it.

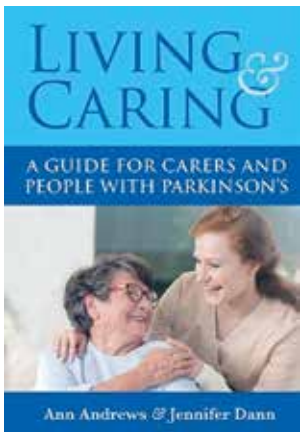
It has made me want to take up yoga.

Highlighting sitar and tabla

Malumba

Book Review

REVIEWED BY **CHRIS JOHNSON**



Living & Caring

By Ann Andrews and Jennifer Dann

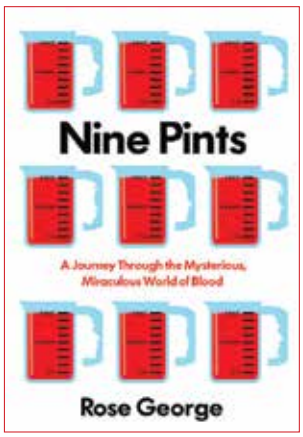
New Holland Publishers | RRP: $32.99

This release from New Holland is the final book in a trilogy about Parkinson's disease. Ann Andrews was diagnosed with Parkinson's in her fifties and has previously authored two books on the subject – *Positively Parkinson's and Grandma's Brain*. This latest work *Living & Caring* is for people living with Parkinson's and for all those who care for them.

Subtitled *A guide for carers and people with Parkinson's*, the book draws on the personal experiences of more than 40 people living with Parkinson's, with many anonymous quotes throughout the book allowing people to really open up about their journeys.

An easy and informative read, the book is very engaging and could be included in the list of reading material doctors might suggest their patients and their families take up.

Co-author Jennifer Dann helps bring the book to life with her command of the language and her extensive journalism experience, including reporting on many aspects of unpaid family care.



Nine Pints

By Rose George

Allen & Unwin | RRP: $29.99

Investigative journalist Rose George has explored blood in depth for this beautifully written book.

Nine Pints takes the reader around the world in pursuit of a greater understanding of the red fluid flowing through our veins.

In an effort to shed light on modern surgery and ancient healing rituals, George retells her encounters with stories from the UK – a leech farm in Wales and a trauma team at a London hospital – to Canada and a controversial plasma clinic – to Nepal and the taboos around menstruation and the challenges they bring to young girls there – and more.

Most humans have between nine and twelve pints of blood in their bodies. *Nine Pints* the book, has nine stories and they are all fascinating reads.

.

AMA Member Benefits

AMA members can access a range of free and discounted products and services through their AMA membership. To access these benefits, log in at **www.ama.com.au/member-benefits**

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.

Volkswagen: AMA members are entitled to a discount off the retail price of new Volkswagen vehicles. Take advantage of this offer that could save you thousands of dollars.

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

Hertz: AMA members have access to discounted rates both in Australia and throughout international locations.

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

Qantas Club: AMA members are entitled to significantly reduced joining and annual fees for the Qantas Club.

Virgin Lounge: AMA members are entitled to significantly reduced joining and annual fees for the Virgin Lounge.

MJA Bookshop: AMA members receive a 10% discount on all medical texts at the MJA Bookshop.