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Pharmacists are not doctors

Pharmacy Guild Stunt, p3

INSIDE

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In this issue

Cover pic: Federal Council meets in Canberra

Pharmacy Guild stunt dangerous and distracting

The AMA has reacted strongly to a Pharmacy Guild policy paper that proposes pharmacists move way beyond their scope of practice to perform some specialised roles of GPs.

AMA President Dr Tony Bartone denounced the proposal and said if the Guild wants pharmacists to undertake the role of doctors then it should encourage pharmacists to first undertake 10 to 15 years of study for a medical degree.

The AMA Federal Council discussed the issue in depth when it met for two days at Canberra in mid-August.

Australian Medicine will be updated online with Federal Council resolutions over the issue and any further announcements from the President.

Some Federal Councillors did note, however, that what the Pharmacy Guild wants is not necessarily what regular pharmacists want.

Immediately following the release of the Pharmacy Guild policy paper *Community Pharmacies: Part of the Solution*, which calls for pharmacists to be allowed to perform "to their full scope" in the health system by treating common ailments and dispensing medication without doctor consultation, Dr Bartone described it as a stunt – but one that had the potential to place patients in danger.

"Patient care suffers, and health and lives are put at risk, when there is fragmentation of health care and the loss of continuity of quality health care," Dr Bartone said.

"GPs study and train for more than a decade to provide quality holistic care for individuals and families through all stages of life.

"The Guild claims that a pharmacist's '*half a decade training prior to being registered*' is sufficient to practise as a doctor, with all the complexity and specialised skills and knowledge that entails. This is simply not true or possible."

Dr Bartone said the Pharmacy Guild's stunt was aimed at taking focus off the Guild's frantic lobbying of the Government over the next Pharmacy Agreement and the controversial location rules, and the threats being posed by Chemist Warehouse, other pharmacy retail chains, and the big grocery chains.

"I do not think that busy, dedicated community pharmacists – who work daily in a collaborative partnership with local GPs, hospitals, and other health professionals in towns and suburbs across the country – would agree with the Guild's push for pharmacists to take over the work of doctors," he said.

"The collaborative relationship between local GPs and pharmacists works well, and should not be eroded.

"GPs know the medical histories of their patients and their families. The enduring long-term and trusted doctor-patient relationship is at the core of safe, high-quality health and medical care in Australia.

"Undermining or diluting this relationship, as the Pharmacy Guild is proposing, is irresponsible and dangerous.

"The Guild should be focused on the interests of its members and individual pharmacists, not looking to make profits from usurping the roles of other health professions."

The AMA supports pharmacists to supply and dispense S2 and S3 medicines. Pharmacists also have an important role in assisting patients with medication adherence and education – this is their field of expertise.

But Dr Bartone said the dangerous part of the Pharmacy Guild proposal is that pharmacists are not trained to assess a health problem or diagnose medical treatments – including medications.

Recent media reports revealed some pharmacists in Queensland had been over-medicating babies who suffer gastrointestinal problems, including with powerful acid suppressants that can be harmful to babies.

Medical practices all around Australia have provisions for providing urgent care to their patients. Many practices keep 'book on the day' appointments for urgent attendances or will fit patients in when required.

Medical practices often provide 24/7 availability for accessing a GP either directly through the practice, or by a deputising service after hours.

The Productivity Commission Report on Government Services highlights that about 75 per cent of patients can get a GP appointment within 24 hours.

JOHN FLANNERY AND CHRIS JOHNSON

Minister focuses on mental health

The Federal Government has made commitments to addressing mental health, promising to work with the States on an integrated system, launching a national children's mental health strategy, funding more mental health centres, and announcing a nationwide survey to reveal insights into Australians' wellbeing.

Health Minister Greg Hunt made the announcement while addressing the National Press Club in Canberra and repeated Prime Minister Scott Morrison's goal of a zero suicide rate for the nation.

"It's your story, and it's my story, and it's my mother's story, who had her battle with bi-polar," Mr Hunt said when turning his address to the topic of mental health.

"But it's a story that every Australian is touched by at some stage... and so we have a national tragedy."

A three-year inter-generational national survey will involve 60,000 Australians being quizzed on their physical and mental health to provide what the Minister described as "a degree of depth and knowledge never before present in our understanding of mental health challenges and conditions".

The Australian Bureau of Statistics will conduct the survey at a cost of about $90 million.

Suicide prevention will get an $8 million funding boost under the next round of the Million Minds Mental Health Research Mission. It will focus on suicide prevention.

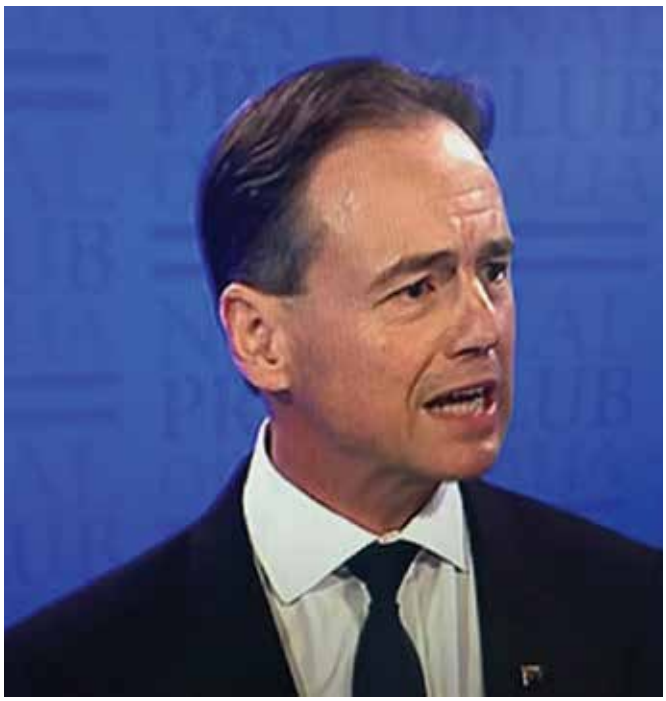
"There is only one target that we consider desirable and this is to head towards zero for suicides in Australia," Mr Hunt said.

"By setting that objective, it says something in itself – that we don't consider this to be acceptable; we don't consider it to be something that the nation must tolerate; we do consider it to be something that we can address and achieve with the right support."

More adult mental health centres are to be built. But to address the problem early, the Government will develop and implement a National Children's Mental Health Strategy to be led by Professor Christel Middeldorp and Professor Frank Oberklaid.

The Minister urged State and Territory Governments to work with the Commonwealth on addressing mental health.

"We would like to work over the next two years to establish a new partnership with the States for an integrated mental health system from the alpha to the omega – from prevention to



recovery – and with understood and agreed responsibilities," he said.

"It starts with prevention, which is a shared responsibility but a Commonwealth lead. We then move to early diagnosis and treatment where the GPs take the lead and the Commonwealth takes responsibility. We move then to the mild-to-moderate treatment phase. This is a shared responsibility but a Commonwealth lead.

"Then we move to the challenge of acute treatment in our hospitals – this is a State responsibility. Saying to my State and Territory colleagues – if there is one thing that I could respectfully ask for, that is dedicated, youth mental health units in each of your States, in as many places as possible...

"And then lastly recovery ... it's naturally the States' lead, but it's a shared responsibility."

Mr Hunt said the Government would continue to tackle stigma around mental illness and encourage people to seek help – and seek it early.

CHRIS JOHNSON

Time for real action on mental and general health issues

Professor Ian Hickie, Adjunct Associate Professor Kim Ryan and Dr Bartone

AMA President Dr Tony Bartone attended the National Press Club to hear Health Minister Greg Hunt deliver his address, which centred mostly on mental health issues.

Dr Bartone later said the Minister had made some good announcements, but that the proof would be in the doing.

"It was great to see the announcements, especially around a childhood mental health strategy," Dr Bartone said.

"And great to see the recommitment into ensuring a reduction in tobacco rates. It was nice to hear about other things like the obesity plan and prevention too.

"But I think that we really need to move along from announcements on strategy and let's see the implementation pathways and let's see the funding.

"We've had many years of consultations, frameworks, taskforces, submissions and everything else. But like I've said, just get on with it now and do it."

Before attending the Press Club, Dr Bartone met at AMA House in Canberra with Professor Ian Hickie, Co-Director of the University of Sydney's Brain and Mind Centre; and Adjunct Associate Professor Kim Ryan, CEO of the Australian College of Mental Health Nurses.

The three discussed the importance of managing mental illness in the primary care setting in the first instance.

"Clearly, in dealing with access pathways in mental health care, there is a lot of focus on the missing middle," Dr Bartone said.

"That's important, because at the moment it is missing. But we can't just solve one part of the puzzle. We need to remember that a significant proportion of GP consults deal with mental health issues. GPs are the first port of call for patients in a very high percentage of cases.

"There's no doubt that the capability of general practice to manage this would be significantly improved by investing in a framework which incorporated practice mental health nurses to support GPs in delivering that care.

"Part of that is the coordination with those secondary centres – the hubs and the referral centres – that basically will fill the missing middle."

CHRIS JOHNSON

New target for Australia to quit smoking

Health Minister Greg Hunt used his Press Club address to set a new target aimed at getting more Australians to quit smoking or not take up the habit at all.

Without providing much detail on how it will be achieved, the new ambitious goal can only be achieved by working with health professionals, he said.

"The Government will set a new target of reducing smoking rates below ten per cent by 2025," Mr Hunt said.

"This may be one of the most important things I've ever had the privilege of being involved with.

"We've already committed $20 million to the education campaign. But there is more to be done and we will develop that with the health and medical and preventive health sectors."

CHRIS JOHNSON

AMA Report Card becomes reality TV

BY AMA PRESIDENT DR TONY BARTONE

> "Clearly, doctors and nurses are bearing the brunt of this stress. They are caring for more patients than ever before as populations rise rapidly, especially aged and chronic disease populations, which further increase the demand."

The *2019 AMA Public Hospital Report Card*, which was released to great effect early in the May election campaign, has become reality television with regular news headlines of underfunding, ambulance ramping, and long patient waits.

The public hospital crisis has been rolling out on the evening news across most States and Territories in the months since the election.

The Report Card painted a picture of hospitals and staff under enormous pressure, and patients waiting too long for care, and it is all true – an awful reality.

The figures show that public hospital performance was worse in 2017-18 (the most recent data) compared to the previous year on most measures. No jurisdiction improved performance across all indicators.

These are not the signs of a public hospital sector in good shape.

Clearly, doctors and nurses are bearing the brunt of this stress. They are caring for more patients than ever before as populations rise rapidly, especially aged and chronic disease populations, which further increase the demand.

A persistent and ever-increasing lack of resources is often being masked by headlines of a record flu season, which is demanding a large share of overstretched services.

There is no denying that when governments underfund, they are making a specific choice to constrain the supply of public hospital services. We all know what the consequences of these scenarios are. I see it daily in my practice, as do most doctors.

Public hospital capacity is determined by funding. Public hospitals can't provide faster access to elective surgery unless they are funded to pay for extra theatre sessions, extra ward beds, extra nurses, and extra specialists.

Ambulance ramping and long waits in emergency departments will not be resolved unless public hospitals have enough money and ward beds with appropriately skilled staff to accept seriously ill patients after they are ready to transition from the expert care of the emergency physicians.

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.

Our public hospitals are struggling and require commensurate additional funding to not just cater for the increasing demand, but to provide innovative caring and treatment conditions to assist in meeting the growing demand.

They need to be assisted to more effectively deal with the new care needs of the changing illness populations, and work as part of a coordinated care team in our health system.

The AMA is sick of hearing the Commonwealth blame the States for funding cuts when the Commonwealth has its own funding cuts built into the indexation formula. States should not complain if they are not contributing their share.

The political blame game must stop.

Both levels of government need to stop the political games and start funding public hospitals to meet demand for public hospital services.

They must help our public hospitals improve the quality of their care, rather than just the quantity of work each staff member must carry.

And they must support our medical and health staff with the resources they need, so they can care for all of us.

Our hardworking doctors, nurses, and health professionals, like all Australians, do not deserve any less.

Dial-a-doctor?

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

I've been attending many meetings recently and listening to government, professional and consumer group representatives talk a great deal about what reform they desire from the health system. It has been sobering and unsettling. There is a great danger of enthusiastic but facile discussion with a perfunctory and thin veneer of consultation with doctors, in the inexorable pursuit of pre-determined actions.

There are three main drivers for change that I hear repeated by consumer representatives (we hope they represent the broader view) in numerous forums:

1. Accessibility.
2. Convenience.
3. Affordability.

You would likely check these off your own list too. But did you notice the glaring omission? Do consumers/patients ever worry about quality? One of the refuges in AMA policy is that much can be defended on the basis that doctors provided a high-quality service. For example, a reasonable, known gap commensurate with the service provided is not inappropriate to see a highly trained doctor of your choice.

Some patients obviously do worry about the quality of healthcare – but others definitely do not and their criteria stops at the above three items. Dial-a-doctor is fine for them. I suspect some take for granted that the huge majority of doctors in this country are fantastic and they do not have to worry about quality in our system. Some possibly rate the perceived severity of their problem and accept a lower quality of care for that which is thought to be a minor ailment (very fraught strategy as we know). Some maybe just have a fixed idea of what they want and do not care who gives it to them. My secretary thinks patients only worry about quality after something goes awry. Distressingly possible.

The paucity of discussion around valuing and investing in high-quality care is very worrying. This is one of the reasons a doctors' fees website is potentially so dangerous – encouraging comparison and provision of care based on cost alone. To be clear, I am very much in favour of increased health literacy and enhancing the ability for patients to make informed choices about their own health care (such as via the Informed Financial Consent document we launched recently). But price is a terrible arbiter/comparator alone and the unintended consequences will be profound and unimagined of the website. More on the Government's doctors' fees website another time.

Our failure to realise that a meaningful portion of our patients would sacrifice quality for accessibility, convenience and affordability has fostered recalcitrance in embracing new models of care. This has allowed an opening for general practice usurpers to gain traction (we all know who they are) on the basis they are more accessible, convenient and/or affordable. Patients also want to be more engaged and have feedback regarding progress e.g. the free electronic health check machines being rolled out around the country.

It would not be fair or appropriate for GPs to be left only treating more complex and difficult disease because usurpers have hived away the 'simpler' work. But if we want to better protect the critical, central importance of general practice (which by extension protects specialist referrals) we must beat the usurpers at their own game. I know there are spare GP consultation slots every day all over the country, GPs are progressively expanding opening hours and that much work is bulk-billed (e.g. in aged care facilities) – but this message is not cutting through. Patients seem to want more or at least something a bit different. We cannot lament patients receiving vaccines in a pharmacy if the cost of the vaccine is less than the cost of seeing the GP.

In this online age, I suspect they want greater online access to services and MUCH greater use of digital strategies for them to stay in contact with their general practice. Can I give a nod to Dr Kean-Seng Lim, the AMA NSW President, who has developed an App for his general practice? Patients can have contact with their GP, input healthcare data and have it graphed, book appointments, and so on. Fantastic! I strongly suspect this is what patients are increasingly demanding. We need to offer it if we are to curtail the usurpers and anneal general practice. Clearly, the AMA has a pivotal role in developing this strategy and assisting us all to harness the full potential of our worth.

Vice President's message ... continued

Our President, Dr Bartone, has achieved the start of significant new investment in general practice by the Commonwealth, but this advocacy effort of the AMA needs to occur concurrently with us making ourselves more appealing in the marketplace. Patients should never waver in desire and comfort to see their doctor regarding a personal health issue, as opposed to seeing anyone else with inferior training, just because they are perceived to be more accessible or convenient.

Quality clearly cannot be lost, but we also need to define it in our own way before someone else does this in a disagreeable, alternate fashion. As we develop new models of care, we will also need to work collaboratively with computer boffins and other progressive minds to develop a profession-led methodology to measure quality and have appropriate data made available to consumers that reinforces the good work of Australian doctors.

The AMA has an important role to ensure quality is not diminished in importance when discussing cost and access. To emphasise its importance, however, we need to be prepared to make quality measures available. In doing this, we hopefully gain a powerful weapon against the usurpers, especially when combined with innovative models of care which give patients what they want. Only doctors can offer quality health care together with convenience, accessibility and affordability. To come out on top, though, in the primary care battleground, we need to watch, listen, learn and act.

INFORMATION FOR MEMBERS

Deputy Co-Chair sought for AMA Council of Doctors in Training

Interested AMA Doctor in Training members are invited to submit a nomination to fill the casual vacancy for the position of: Deputy Co-Chair, AMA Council of Doctors in Training. This position is open to any AMA doctor in training member and will run until the AMA National Conference in May 2020.

The AMACDT has 2 Deputy Co-Chair Positions. The position of Deputy Co-Chair is intended to support the work of the Chair of the AMACDT so that the AMA can participate effectively in a wide range of forums and activities relevant to the interests of doctors in training.

In considering candidates for this position, the following criteria will be considered:

- availability of the nominee to represent the AMA in a wide of range of forums and activities,
- previous participation of the nominee in AMA committees at state or federal level,
- the previous participation of the nominee in other medico-political organisations,
- contribution in one or more the following areas:
  - + Leadership – in medical education and training, doctor health, wellbeing and safety and/or engagement and communication
  - + Collaboration – in workforce and/or membership
  - + Contribution – in public health and/or e-health.

Interested members are invited to submit an application for this position, including a CV and statement of claim in support of their nomination. The statement of claim should be no longer than one page. Nominations will close at 5.00pm on Sunday, 1 September 2019

Following this, AMACDT will consider nominations out of session with a view to an appointment being made before the next meeting to be held in Canberra on 26-27 October 2019.

The current Terms of Reference for the AMA Council of Doctors in Training can be found at: https://ama.com.au/sites/default/files/documents/AMACDT%20Terms%20of%20Reference.pdf

Questions about the position, AMACDT governance arrangements and operation can be referred to Dr Tessa Kennedy, Chair, AMACDT on cdt.chair@ama.com.au

Nominations can be emailed to scross@ama.com.au

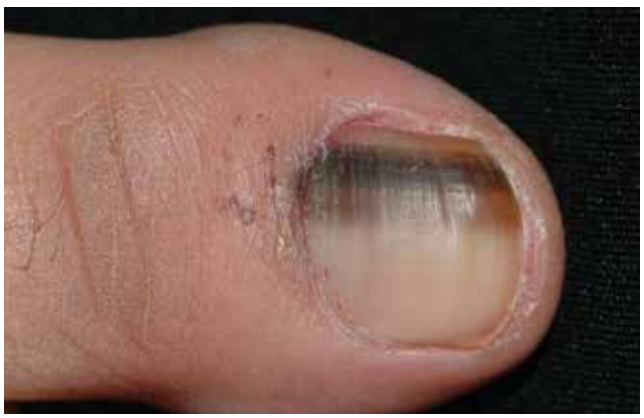
Please feel free to forward this to any AMA doctor in training member who may be interested in nominating for this position.

Scene and heard

Health Minister Greg Hunt and Dr Bartone at the National Press Club.

With psychiatrist and leading mental health advocate Professor Patrick McGorry AO, and Health Department Secretary Glenys Beauchamp PSM.

Dermatologists concerned about melanoma of the nail



The Australasian College of Dermatologists (ACD) is highlighting awareness of melanoma of the nail, saying concerns should be brought to the attention of general practitioners in the first instance.

A dark line under a fingernail or toenail will in most cases be harmless, but it can be a sign of melanoma of the nail. Other signs of melanoma of the nail include the stripe being very dark; the border of the stripe being blurred; changes in an existing stripe; and if the patient has a family history of cancer.

Associate Professor A Johannes S. Kern, dermatologist with the ACD, who specialises in nails, said GPs will refer patients to the right specialist.

"Dermatologists specialise in the area of nails – not just skin – and are the best doctors to find the right spot to biopsy and diagnose if it is melanoma or not," Professor Kern said.

As with any cancer, staying educated and maintaining regular self-examinations are crucial. The ACD is asking people to discuss anything that looks suspicious with their GP as soon as possible, as the key to surviving melanoma is early detection. The GP will refer to a dermatologist if necessary.

RVTS applications open

Round Two applications for the 2020 intake of the Remote Vocational Training Scheme (RVTS) open on September 2.

The RVTS is a three to four-year vocational training program for medical practitioners in rural, remote, and Indigenous communities throughout Australia.

The training program is delivered via structured distance education and supervision and meets the requirements for fellowship of both ACRRM and the RACGP.

Applications for the 2020 intake will close at 5.30pm on September 20, 2019.

Further information and the complete eligibility criteria are available at: www.rvts.org.au

Federal Council gathers in Canberra

The AMA Federal Council met at Canberra in August to discuss a range of pressing issues, as well as debate resolutions from the AMA National Conference in May.

Lead stories will follow on some of the bigger items discussed and decisions reached. *Australian Medicine* will be updated online and in future editions as these announcements are made.

In his President's report, Dr Tony Bartone noted that the AMA's advocacy efforts remained strong and reached the highest levels of policy making in Government and the bureaucracy. He outlined numerous meetings he had had with Health Minister Greg Hunt and other Government Ministers, MPs and Senators across the political spectrum, with Government department and agency bosses, and with leading mental health organisations.

Leading up to the Federal election in May and since then, he said, has been a hectic period with results showing how influential the AMA is in health policy.

Under questioning about the Government's intent to repeal the Medevac legislation that currently gives doctors the say in whether refugees on Manus Island or Nauru should be brought to mainland Australia for medical treatment, Dr Bartone said the AMA's position remained strong.

"Irrespective of whatever the Parliament decides to do, our position remains clear around ensuring independent access to medical care for refugees and asylum seekers. It hasn't changed one bit," he said.

Federal Councillor Dr Paul Bauert said he was concerned that the Government would pull out all stops to repeal the legislation and that the AMA should come out strongly in support of retaining the Medevac laws.

The repeal legislation has already passed in the House of Representatives but will face a tougher test when the Senate debates it later this year.

On other issues, the Federal Council agreed that all employees should have access to a minimum of ten days of paid domestic violence leave.

It also agreed to join the Global Green and Health Hospitals Network.

The methodology for determining AMA fees in line with the Medical Benefits Schedule (MBS) Review implementation was discussed.

A simple but defensible, overarching methodology was decided on going forward.

Federal Council endorsed the establishment of the AMA Fees List Committee to oversee and be responsible for the AMA List of Medical Services and Fees; and it approved the terms of reference for that Committee.

Federal Council agreed to advocate for a single employer model as an alternative to fee for service arrangements to deliver equitable remuneration and employment conditions for GP registrars, and between GP registrars and non-GP registrars, while at the same time meeting the needs of supervising practices.

Keep checking *Australian Medicine* online for further news from the Federal Council's deliberations.

Award for outstanding service over three decades

Dr Bartone presents Mr Boyatzis an Outstanding Service Award

AMA stalwart Paul Boyatzis has been recognised for his dedication to the Association, with an Outstanding Service Award.

AMA President Dr Tony Bartone presented the award to Mr Boyatzis when the AMA Federal Council Meeting in Canberra in August and noted he had served the organisation well for more than 30 years.

He also received a standing ovation from the whole Federal Council.

Mr Boyatzis has been the Executive Director and CEO of AMA (WA) since 1988. He announced his retirement earlier this year.

Dr Bartone said Mr Boyatzis had been a tireless campaigner of the AMA at both the State and Federal levels and had worked hard for the betterment of the organisation.

Dr Bartone noted how much the world had changed since Mr Boyatzis began his work with the AMA and how he had helped keep the AMA contemporary and able to meet the challenges it faced.

He said he took over as CEO of AMA (WA) at a time of significant hardship for the small organisation in Perth and transformed it into a large and influential membership-based entity.

"I'd like to note that this is Paul's final meeting here at Federal Council and we'd like to mark that occasion with this plaque," Dr Bartone said.

The award states: In recognition and acknowledgment of his outstanding contribution to the AMA, at both Federal and State level, and excellence in furthering the objectives of the medical profession and the health of the Australian community."

Upon receiving the award, Mr Boyatzis thanked the Federal Council for it and gave some final tips on where the AMA should focus its attention into the future.

And he said the AMA was in a strong position, remaining at the peak of health and medical advocacy in the Australia.

"The AMA is coping ok. Anyone telling you otherwise is wrong," Mr Boyatzis said.

Mr Boyatzis was the recipient of the AMA (WA) President's Award in 2018.

CHRIS JOHNSON

Parents are trying almost anything to keep colds away from their kids

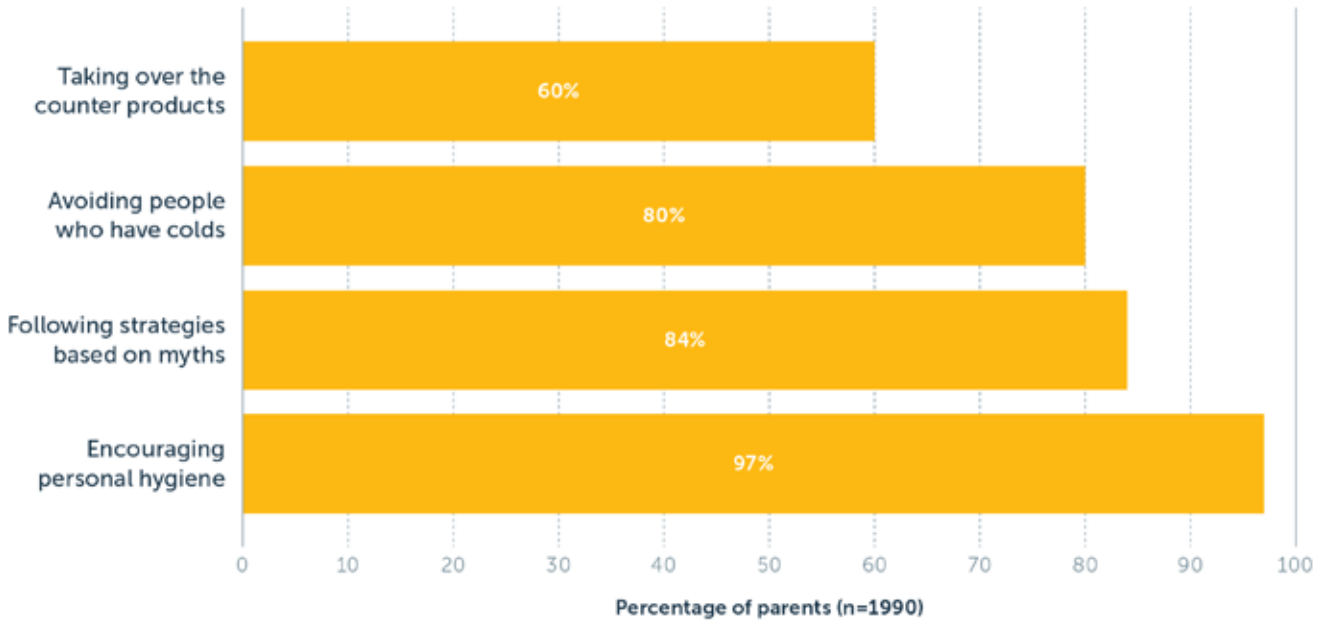
A newly released survey has revealed that many parents do not know the best ways to help prevent their children from catching colds, with some turning to myths and unnecessary supplements.

At the height of winter when children are catching colds at a high rate around the nation, the Royal Children's Hospital (RCH) has released its National Child Health Poll that found many parents confused over the best ways to ward off a cold.

The poll of 1,990 parents who care for 3,630 children aged one month to less than 18 years found:

- Less than half of parents (46 per cent) know that frequent handwashing is the most effective way to prevent catching a cold;
- The vast majority of parents are unaware of just how common a cold is with only one in ten parents (10 per cent) knowing that, on average, a preschool aged child has at least six colds a year. More than a third of parents (35 per cent) incorrectly believe that children who get more than a couple of colds a year have a weak immune system;
- Sixty per cent of parents are giving their children over-the-counter products such as vitamins or supplements to aid cold prevention, with vitamin c the most popular, even though there is no scientific proof that these products will stop a child from catching a cold; and
- Worryingly, one in eight parents (13 per cent) report giving their children antibiotics as a measure to prevent catching a cold and one in four parents (25 per cent) believe that taking antibiotics can stop a cold turning into the flu. The cold is a virus and does not respond to antibiotics.

Strategies parents use to try to prevent colds in children



Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

WITH CHRIS JOHNSON

Government agency updates charter on healthcare rights

The Australian Commission on Safety and Quality in Health Care has launched a revised charter of rights that encourages people to be actively involved in decisions about their health care.

The revised *Australian Charter of Healthcare Rights* is the second edition of the Charter and describes rights that apply to people in all healthcare settings across Australia.

It reflects an increased focus on person-centred care and says people receiving health care have every right to engage with their healthcare providers and have input about decisions being taken.

The Charter outlines what every person can expect when receiving care and describes seven fundamental rights including: *access, safety, respect, partnership, information, privacy* and *giving feedback*.

Its use is embedded in the National Safety and Quality Health Service (NSQHS) Standards that all hospitals and other acute health services must meet to stay accredited.

Commission Chair Professor Villis Marshall AC said the release marks the first major update to the original Charter, adopted by Australian Health Ministers in 2008.

"The inaugural Charter was a landmark document and the second edition builds on that strong foundation," Professor Villis said.

"Community attitudes to health are constantly evolving and we reviewed the Charter through that lens, to ensure it reflected what the wider community believe are their appropriate healthcare rights in today's landscape, and to clarify areas that required further explanation.

"The new Charter explains a patient's rights to privacy in practice, it expands on the importance of informed consent and open disclosure, and it reflects the increased focus of the medical profession on partnering with the consumer in the delivery of health care in Australia."

The Charter also aims to assist healthcare professionals, who can use it to discuss with patients their rights when using the healthcare system. The Commission has developed resources to support healthcare providers when discussing patient rights.

Agreement found on stillbirth recommendations

The Federal Government recently accepted the recommendations made by the Senate Select Committee on Stillbirth Research and Education Report, engendering gratitude in the Senate on its last sitting day of the recent session.

Labor Senator and Committee member Kristina Keneally thanked the Government for responding to the report and agreeing to its recommendations.

"This was a significant report. For the first time in Australian history we have a national set of recommendations to address the tragedy of stillbirth in this country," Senator Keneally said.

"Stillbirth is a tragedy that affects six Australian families a day; 2,200 babies a year are lost to stillbirth. In the last 20 years, the rate of stillbirth has not changed in this country. I use the 20-year figure because that's as long as we have been keeping accurate — or at least somewhat accurate — data.

"In those 20 years, some 44,000 babies, who were wanted and loved by their parents, were lost to us. Quite tragically, they were lost to us in large part — a large number of them — because we as a country, collectively, had not spoken about the issue of stillbirth, had not sought to understand what causes stillbirth and were not providing parents and clinicians with the advice that would help prevent stillbirth. The rate of stillbirth in this country is higher than the road toll. It is the number one killer of babies under the age of one.

"This inquiry allowed parents who have experienced stillbirth to speak. And speaking is important, because this is an issue where remaining silent has been of great detriment to the Australian community and to Australian families. Remaining silent has meant we don't talk about it. It's meant we don't address it. It's meant that stillbirth has been a tragedy people have suffered in silence. We viewed it as a private tragedy, not a public health problem. And it is a public health problem."

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

In responding to the Committee's report in July, Health Minister Greg Hunt said the Government had agreed to, or agreed in principle to, all the recommendations.

The Government's response includes:

- developing a National Stillbirth Action and Implementation Plan in collaboration with state and territory governments and in consultation with bereaved parents, health professionals, researchers, advocacy groups and other stakeholders. The recommendations in the Senate Committee's Report will be central to informing the development of the plan;
- investing in stillbirth research;
- developing best practice, culturally appropriate resources for health professionals and parents and families, including more intensive support options for bereaved parents and families following stillbirth; and
- working with States and Territories to make improvements in several key areas including improving national perinatal mortality data collections, improving access to publicly-funded stillbirth autopsies, building the perinatal pathology workforce, developing more culturally and linguistically appropriate models of care, bereavement support and protocols for public hospitals and community health services.

"We thank the individuals and organisations that have contributed to the report, especially those people who have shared their personal stories," Mr Hunt said.

"In response to the report, the Government is investing $52.4 million in perinatal services and support. This will help prevent, reduce and assist the more than 2,000 families affected by stillbirth each year."

Funding, not penalties, for hospitals, says AMA

The AMA lodged a submission on the Pricing Framework for Australian Public Hospital Services 2020-21, and welcomes Independent Hospital Pricing Authority's (IHPA) proposed interest in pricing for quality. But it says this must not be pursued via the use of funding penalties as 'incentives'.

"Public hospitals don't need an incentive to provide quality care – they need more funding to pay for additional staff, additional staff time with each patient, sufficient hospital beds, and other additional resources inherent in quality care," the submission states.

"There is no evidence to demonstrate funding cuts improve quality and safety of care. The proposed adoption of individual healthcare identifiers into large hospital datasets used by IHPA for the purpose of pricing public hospitals will likely achieve the aim of tracking patient interactions with the health system across care settings.

"It is disappointing the motive for this is to improve the ease of penalising public hospitals for apparent avoidable readmissions. While it is reasonable to expect public hospitals to provide a full patient discharge summary and post discharge care plan to the patient's GP within 48 hours of discharge or sooner – it is unreasonable to financially penalise the hospital if patient readmission is still required."

The AMA urges the IHPA to seek expert advice on the risks of patient re-identification before the public disclosure of these large de-identified public hospital data sets for research purposes.

The full submission can be found at:

https://ama.com.au/submission/ama-submission-independent-hospital-pricing-authority-pricing-framework-australian-public

Safety over convenience

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

> "They are an important safety mechanism to ensure that patients do not receive an inappropriate medication or dosage, and that patients understand how to safely and effectively use the medication."

The Queensland Government has agreed to run pharmacy prescribing trials following its pharmacy inquiry. This potentially undermines patient safety and quality prescribing. It also flies in the face of the framework agreed to by the Australian Health Practitioners Regulation Agency (AHPRA) and the Coalition of Australian Governments (COAG) to ensure a nationally consistent and transparent process for non-medical health practitioners to prescribe or expand their prescribing. Not only is there a risk of facilitating disparate prescribing rights and education standards from one State to the next, prescribing and dispensing should be kept separate to help ensure patient safety.

Pharmacists provide an important and independent set of eyes when dispensing prescribed medications. A fundamental part of their role in dispensing medications is to assess the prescribed dosage is safe and appropriate, check for allergies, contra-indications or drug interactions. They are an important safety mechanism to ensure that patients do not receive an inappropriate medication or dosage, and that patients understand how to safely and effectively use the medication. Cloud that view and patient safety will undoubtedly be compromised, and compromised for a false premise, that of enhanced access to care. Quality of care will have been sacrificed to meet a constructed convenience.

The Pharmacy Guild wilfully promotes the idea that accessing general practice is difficult or costly. Yet, the data on patient experiences published by the Australian Bureau of Statistics, disputes this. Of those who saw a GP for urgent medical care, two thirds were seen by a GP that day and within four hours. Less than two in ten reported waiting longer than 'they felt' acceptable for an appointment. Only four per cent of patients who saw a GP in the last 12 months delayed or did not see a GP due to cost.

For the AMA, it is indefensible that the patient protections currently in place are trying to be circumvented by those with a pecuniary interest in both prescribing and dispensing. Given that pharmacies receive a dispensing fee from Government for each PBS medication they dispense, it is easy to see they would have a conflict of interest if pharmacist staff could also prescribe such medications.

Safe, high quality patient care depends on multidisciplinary teams of health practitioners, led by a medical practitioner, working together within their scopes of practice. Four years of training in pharmacy can not be compared to the 10-14 years of training undertaken by a GP. Training that delivers the required competencies to autonomously prescribe as described in the *Health Professional Prescribing Pathway*.

What the AMA wants to see is non-dispensing pharmacists integrated within general practice and working collaboratively with GPs and patients to enhance patient medication adherence, improve medication management and provide education about medication safety. Working within a medically-led and delegated team environment, where collaborative arrangements are formally documented and core competencies for safe prescribing are achieved and maintained, provides the best opportunity for pharmacists to fully utilise their training and expertise, within their scope of practice and without fragmenting care.

Pharmacists have a role in supporting quality care. The AMA does not dispute this. But it is in conjunction with GPs and other medical practitioners within appropriate prescribing and therapeutic protocols. What the AMA does dispute is that pharmacists be enabled to independently and autonomously prescribe S4 and S8 medicines. In addition, the AMA will strongly oppose any model of prescribing by pharmacists where the pharmacist is connected to a retail pharmacy.

Fifty years of the Public Health Association of Australia

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

The 50th anniversary of Apollo 11 refreshes and amazes us with its boldness, commitment, and quaint computing power. Another, much quieter, 50th anniversary is also in progress. What is now the Public Health Association of Australia began in 1969. It has grown into a strong collective of people, many of them health professionals, committed to improving the health of our communities. The formal celebration is scheduled for Adelaide next month.

> "People will have the freedom to lead lives they have reason to value if they live in a society that values their lives."

It is interesting to note how much of the energy of formation came from people who had worked in Papua New Guinea. The lessons they learned, written large in the highlands and townships of that country, of what may be achieved by immunisation and networks of aid posts providing basic care of first contact staffed by 'doctor bois' and basic-trained indigenous maternal and child health nurses, encouraged them to consider what more could be done in public health in Australia.

From the outset, the Association sought to foster fellowship among public heath 'believers'. It honoured and nourished research, especially epidemiology, and its application. Its diversity was reflected in the cumbersome name – the Australian and New Zealand Society for Epidemiological and Research in Community Health or ANZERCH. While admirably inclusive, the title was awkward and media-unfriendly.

In the mid-1980s, encouraged by support from the then Federal Minister for Health, Neal Blewett, it was changed to the Public Health Association – PHA. A similar association was soon formed in New Zealand and hence ours become known as PHAA, the last A obviously standing for Australia. Today it is a robust organisation with 1700 members from over twenty disciplines and in all States and Territories and 18 special interest groups. It has produced a plethora of policy statements to be used in advocacy.

The PHAA recently listed what it perceives as major achievements in Australian public health over the past 50 years. Every one of these successes required collaboration and PHAA claims no monopoly. The list includes:

- Folate helped reduce neural tube defects.
- Immunisation and eliminating disease.
- We helped contain the spread of HPV and its related cancers.
- Oral health: we helped reduce dental decay.
- Slip! Slop! Slap!: We helped reduce the incidence of skin cancer in young adults.
- Fewer people are dying due to smoking.
- We helped bring down our road death and injury toll.
- Gun control: We worked to reduce gun deaths in Australia.
- HIV: The spread was contained.
- Finding cancer early: Screening prevented deaths from bowel and breast cancer.

Another aspect of reflection, beyond the milestones of achievement 'on the ground', is to ask about the overarching goal. What did we seek to achieve through our efforts, and of course by no means ours alone, and how much of that goal is durable, applicable today as a guide and stimulus to future action?

Amartya Sen, born in Santiniketan, India, and aged 86 in November, was awarded the Nobel Memorial Prize in Economic Sciences in 1998. He has made inspiring contributions to development economics. Famously, he asserted that famine (not undernutrition) is a political construct. During the Irish potato famine, Ireland continued to export food to Britain, for example.

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Myths and misinformation about rural internships

BY JACOBA VAN WEES, CHAIR OF AMSA RURAL HEALTH

This month I have invited Ms Jacoba van Wees, Chair of AMSA Rural Health, to write a guest column on rural health from the medical student perspective. It is time to quietly listen to our new generation of junior doctors, as they can help us solve our workforce issues – Dr Sandra Hirowatari, Chair, AMA Council of Rural Doctors.

Internship. It's the word that makes medical students quiver in fear of responsibility and expectations. It's also the word that makes students excited, and hopeful. It marks the epitome of everything they've worked towards during the last four to six years of study. It is also one of the most terrifying aspects of medical students' professional lives thus far, and marks the beginning of their careers.

> "Through my role within AMSA Rural Health, I have had the privilege to hear many unique perspectives on rural internships, particularly students who have just endured the internship application process themselves, and the emotional journey that accompanied it."

The above feelings are not unique – every medical student has contemplated the day they make the fated transition from student to intern. It becomes a much more complex, muddled emotional experience when you add rurality into the mix.

Through my role within AMSA Rural Health, I have had the privilege to hear many unique perspectives on rural internships, particularly students who have just endured the internship application process themselves, and the emotional journey that accompanied it. As a part of my role, I am often asked: "What makes someone want to practise rurally when they graduate?"

There is no simple answer, unfortunately. While there is evidence that positive rural experiences as a student and rural origin both increase the likelihood of someone practising in a rural area as a junior doctor, real and perceived barriers can dissuade even the most passionate of would-be rural doctors.

There is a stigma surrounding rural internships, and fear amongst medical graduates that spending your intern year in rural or regional hospital decreases your chances of being accepted into a number of colleges.

Medical students are constantly being bombarded with the idea that you will never make it onto certain training programs unless you do your internship in a metropolitan hospital. There are ongoing concerns that a lack of exposure to certain specialties as a PGY1 and 2 will hinder your chances of training in that field.

Some aspects of these fears are based on legitimate concerns for interns, such as lack of access to consultants in certain fields in order to gain appropriate references. However, many of these concerns are persistent despite there being little evidence that a rural internship will exclude you from any specialty training program. In fact, some colleges are now rewarding rural practice, such as RANZCOG, which awards two points to applicants for completing a minimum of one-year full time as a non-bonded trainee in a rural area.

The stigma runs even deeper than that – with a fear among students that if you 'end up' rural, you won't ever be able to obtain a position at any metropolitan hospital. In Victoria, final year medical students are provided with a 'Z-score', which is a standardised score comparing students from the different Victorian Medical Schools that indicates how far below or above the mean a student is.

This system of internship allocations further exacerbates negative perceptions towards rural internship programs as the more competitive metropolitan hospitals end up with a cohort of students with a higher average Z-score, implying that students who receive rural internship placements performed worse academically than their peers who receive metropolitan internship allocations.

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Rural health ... continued

Many of my peers often talk about how awful it would be to 'end up' rural, and cannot fathom that I would actively choose to do rural terms as both a student and, hopefully, junior doctor. In my clinical placements as a student so far, the experiences I've had in a rural area have been far superior to those I've experienced in metropolitan tertiary hospitals. I attribute this to the cumulative effect of increased exposure and experience, smaller teams with more access to supervision, and strong support from peers and mentors. But for my peers who haven't had the opportunity for positive rural experiences, there is no incentive drawing them to rural internship programs.

In my eyes, the fear of missed opportunities is the biggest deterrent from rural internship programs – fear of missing out on relationships, support, mentors, training programs, friendship and so much more. Those of us who are passionate about rural health know that this isn't always the case, but the onus shouldn't fall on the students and interns to educate themselves to decipher fact from fiction.

We need greater visibility of the many positive aspects of rural internship, especially from current rural interns and junior doctors. We need the good stories to outweigh the myths and misinformation. We need to publicise and reward the health services that provide junior doctors with support, and show junior doctors that they will be welcomed into rural communities. We need to hear the specialty colleges and health services actively dispelling falsities and promoting rural specialty training. I certainly do not have the panacea to our rural workforce shortage, but what I do know is this – a perceived barrier can still hinder our rural workforce. Together we must strive to eliminate these barriers.

Public health opinion ... continued

The crucial underpinning of community development in Sen's thesis is freedom – from poverty and other captivating social circumstances.

One sentence from Sen's writing struck me when I considered PHAA turning 50. He wrote: "Our task is to create the conditions for people to have the freedom to lead lives they have reason to value."

It is worth parsing that statement. Contributing to the conditions that allow all our citizens the freedom to lead lives they value is quite a goal, but surely a good one for public health.

There's a precondition. People will have the freedom to lead lives they have reason to value if they live in a society that values their lives. In New York in 2003, I met a health educator who told me that disadvantaged Harlem youth were resistant to all her efforts to reduce their smoking. "Why should we quit?" they asked, "when we'll be dead in five years?"

If health is not regarded as a resource to be shared among all citizens, or quality education is restricted to those who can pay, or where the environment is a resource to be stripped naked for the wealth of a few, or where our hearts are closed to strangers, then we send a negative message to all our people. By contrast, a society that values its citizens motivates them to value themselves. Such valuation can happen anywhere, any time. It is relevant to general practice.

My youngest son is completing his third year of medicine and was recently attached to a rural Aboriginal medical service for three weeks. He was deeply moved by the dedication and professionalism of the staff, which included general practitioners, and the value they attached to often extremely challenging and difficult patients, some with very low self-esteem. Something kept these people at it.

I suspect that the staff in such settings take strength from statements such as Sen's where he defines our mission as creating the conditions for people to have the freedom to lead lives they have reason to value. This can partly be 'big ticket', done by policy makers and politicians. It can also be done by us as individuals. That is the grand opportunity of medicine and public health.

Stephen Leeder was national president of PHAA 1985 to 1988 and again 1994 to 1998. He is an emeritus professor of public health and community medicine at the University of Sydney.

2019 AMSA National Convention: Unlocking our potential at the largest student-run conference in the Southern Hemisphere

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

"Does anyone know why I have seen groups of people wearing capes and animal costumes the last few mornings?" asked a Hobart local on an online forum earlier this month. "Is there a Harry Potter fan convention on?"

On the 7th of July, more than 800 medical students from all around Australia converged on Hobart, Tasmania. For many, it was their first time visiting our southern-most State. For the UTAS medical students running the event, it has been a two-year undertaking to bring AMSA's 60th National Convention to life.

Throughout the week, students took part in a hands-on academic program including esteemed speakers such as Dr Sally Cockburn and Professor Nicholas Talley. Workshops ranged from plastering to fermenting foods and for our more adventurous delegates, excursions to Mount Wellington and other Hobart must-sees. In the middle of the week, teams from each medical school were pitted against each other at our Sports Day and Emergency Medical Challenge (congratulations to my own Western Sydney University for their first championship!). And to round out our busy days, Hobart delivered one of our most unique social programs, with the Museum of Old and New Art as the highlight venue of the week.

Convention does more than let students learn and socialise; during the week, students are challenged to question the current state of medical education. Opening the event, Governor of Tasmania, Her Excellency Kate Warner, used her platform to remind students of the importance of advocating for patients, calling on a greater focus of the education on intimate partner violence in medical school. During my closing speech, I addressed the bleak picture around the support and mental health of medical students and junior doctors as of late.

"In recent times, we have lost friends, we have lost peers and we have lost mentors to a medical system that failed to support them. As our final year medical students wait on internship offers, we have seen multiple hospitals lose college accreditation due to bullying and harassment, and others lose trainees for unsafe working conditions. In just the last month, we have heard of the suicides of two junior doctors. I see this, and I am terrified for my friends who are graduating. I am terrified that our superiors, our faculties and our hospitals are failing us; and all I can do is implore that we all take care of each other when others will not."

It is a sombre note to close on, when compared to the energetic fun and close camaraderie between medical students I see at every Convention year on year. But it is a reminder that medical students cannot wait for others to advocate on our behalf; our strongest supports are those around us.

It is an evolving challenge to keep AMSA's National Convention at the forefront of a medical student's calendar, especially as our student population changes, along with their interests and priorities. There is no shortage of academic conferences geared towards medical students, and plenty of social nights in our calendars too. Convention sets itself apart by bringing together like-minded students to learn, to let their hair down (sometimes in capes and costumes), to advocate and to take care of each other from every corner of the country.

Congratulations to Declan Hilder, 2019 AMSA National Convention Convenor, and his amazing team for putting on such an amazing event.

Recruitment Manoeuvres

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

It's that time of year again. Selection into training, selection into jobs, selection of the place you're going to call home for the next 6-24 months until we do it all over again.

Compared to the recruitment and selection processes in other countries, where a one-time 'match' might be all that is required between medical school and completion of specialty training, medical training pathways in Australia can be a convoluted bureaucratic adventure. To say the least.

We've discussed previously many of the advantages of our formative generalist years, and perhaps the need to actually increase flexibility to move laterally between training programs. But this annual-ish cycle of the whole workforce re-application for employment (that you're so likely to find again that a bank will usually wager you a mortgage) does mean a whole lot of CV updating, selection criteria writing, closing-date server crashing, post-nights interviewing, stress-inducing madness. For everyone involved! We mustn't forget that the burden of the process falls equally on the shoulders of senior clinicians administering it.

Sometimes the process even threatens to fold back in on itself. I've certainly applied in August for a registrar job identical to that to which I'd been promoted in July, been appointed 12 months ahead of a start date, and faced re-applying for a job I hadn't even started due to intervening maternity leave. Thankfully in my experience the common-sense contract extension has been a thing, but not everyone is as lucky.

It's unsurprising really for everyone, employees and employers alike, to get a little bit over it.

It's difficult to create recruitment processes that discriminate (as they should) between candidates to identify those who are most suitable for the position being offered, while avoiding unconscious bias leading to unfair discrimination according to irrelevant characteristics (gender, ethnic background, fashion sense, level of extraversion, or more commonly and insidiously – just the person you know) all in a 10-minute interview slot.

Enter the pre-interview. Forbidden by most jurisdictional policies, these shady but totally mainstream meet-and-greets continue to occur, particularly among physician training circles. Like most things, its persistence is as much about inertia as anything. Happily some sites are taking the lead by creating group informational sessions, in an attempt to showcase their training program while at once trying to reduce the likelihood of a candidate being asked something "we can't ask in the interview" – because it's likely irrelevant and opens the door to conscious or unconscious discrimination of the bad kind. So maybe just don't ask at all?

Other training programs, possibly out of fear of anti-competitive behaviour (ahem), seem to have swung the pendulum far in the other direction. In attempts to provide transparent, objective and defensible criteria against which to rank and choose candidates, we are seeing a burdensome list of points for a CV that is not so facetiously described as a needing to be bought. By attending approved courses, acquiring approved postgraduate degrees, attaining success in examinations of a specialty in which you haven't even technically started to train.

All this, seemingly ever more divorced from what should surely matter most – your clinical experience, acumen, and professional qualities.

All this, to have a series of temporary contracts that offer little in the way of job security or at least certainty of where you'll call home, little opportunity for longitudinal supervision for trainees, little sense of return on investment for supervisors, and a lot in the way of paperwork, mandatory training modules, and attempts to time leases and conception to fit in with term changeover.

Not to mention anyone with a significant life event actually falling on term changeover is destined never to celebrate it, as you're either packing up and moving, or rostered on to cover those who are.

All this, however, can change in time. Looking for a place to start?

- Please remember not to ask or answer irrelevant, inappropriate personal questions that have the potential to convert bias into discrimination ("I'm sorry, could you repeat that? It sounded like you were asking a question that did not relate to the selection criteria" is the best retort I've heard!)
- Ensure your selection panels are as diverse as the candidates you want selected.
- Seek to ask "why not" rather than "why" when considering requests for flexible work and longer contracts.
- When a trainee is not successful, feedback is essential for them to either do better or try elsewhere next time.

New restraints regulations for residential aged care facilities

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

You don't have to look far to find examples of inappropriate use of restraints on older people living in residential aged care facilities (RACFs). The ABC's 7.30 program ran a segment in January on the use of restraints in RACFs and featured a resident, Terence Reeves, who was allegedly restrained to a chair for 14 hours a day and was given risperidone without the consent of his family. The man deteriorated significantly in his time at the RACF. The family gave evidence to the Royal Commission into Aged Care Quality and Safety in May.

> "Broadly, actions required before a physical restraint can be used include a documented assessment by an approved health practitioner…"

Shortly after the 7.30 segment, then Minister for Senior Australians and Aged Care (and Indigenous Health) Ken Wyatt announced that changes to regulation around the use of restraint would be released "within weeks". The AMA participated in Chief Medical Officer Professor Brendan Murphy's Aged Care Clinical Advisory Committee to develop the new regulations. The *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2014* was tabled in early April and came into effect on the 1 July 2019.

Mr Wyatt stated: "We will not tolerate the use of physical and chemical restraints. Restraint must only be used as a last resort."

The AMA's *Position Statement on Restraint in the Care of Older People* states: "Restraints should only be prescribed where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained…The use of restraint must always be the last resort after exhausting all reasonable alternative management options." Several aspects of the new regulations align with AMA's position.

Aged care providers must now meet several conditions before a restraint can be used on a resident.

Broadly, actions required before a physical restraint can be used include a documented assessment by an approved health practitioner (i.e. a medical practitioner, nurse practitioner, or registered nurse) who has day to day knowledge of the resident, alternatives to restraint have been used and documented, and that the provider has informed consent from the resident or their representative. Restraints can still be used in an emergency, however this must be documented as soon as practicable, and the resident's representative should be notified. The restraint must be used for the minimal amount of time necessary, and the resident must be regularly monitored.

Broadly, actions required before a chemical restraint is administered include assessment and documentation by a medical or nurse practitioner who has prescribed the chemical restraint and has concluded the restraint is required. This must be recorded in the care and services plan, as per the Aged Care Quality Standards requirement. The resident's representative must be informed before the restraint has been administered, or as soon as practicable. The resident must be regularly monitored, and the practitioner must be provided with updates regarding the use of the restraint. The provider must also document any alternatives to restraint that have been used as well as the reason why the restraint is necessary.

Professor Murphy, in his hearing for the Royal Commission into Aged Care Quality and Safety, discussed blocking doctors from prescribing risperidone a second time, beyond the 12-week maximum as a condition under the Pharmaceutical Benefits Scheme:

"If you want to use it beyond 12 weeks you have to go to a different authority, and that will put up a lot of red letter warnings saying that this is seriously aberrant behaviour and it is only in certain circumstances you should consider this, and you should probably be consulting a geriatrician or a psychiatrist. So we can use the PBS as a tool but it's not a regulatory mechanism to stop unsafe practice, and I think – I don't think we should pursue it in that way."

The Royal Australian College of General Practitioners cautiously welcomed the change.

Medical practice ... continued

Time will tell whether these new regulations improve the use of restraints. Beyond regulation, there are several things aged care providers and doctors can do to reduce the use of restraints.

This includes training staff to:

- understand ethical, medical, and legal issues and responsibilities when using restraints, and consult the older person's usual doctor before using a restraint to determine whether there are underlying causes to their distress (e.g. they are in pain);
- Ensure the aged care environment is welcoming. This includes the physical space but also through the social culture of the RACF and its staff;
- Encourage the older person and their family to develop an advanced care plan that states their preferences, values and goals of care to help guide health care decisions should they lose capacity in the future. As part of advance care planning, they should be encouraged to appoint a substitute decision maker (SDM) who will be authorised to make health care decisions on their behalf should they lose decision-making capacity in the future; and
- Ensure adequate numbers of registered nurses available to ensure medications are managed properly and the older person is monitored for any side-effects.

The Government also has a role to play by implementing a minimum aged care staff to resident ratio that reflects the level of care need of residents and ensures 24-hour on-site registered nurse availability. Inadequate staffing is a major cause of missed care in RACFs.

Our older patients deserve better care.

Artificial intelligence in public health – not the slow to emerge oxymoron you may have imagined

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

Every day may appear the same as the last in the public hospital system, but technology does alter. The equivalent of changes to your first clunky mobile telephone to the mobile computer/camera currently in your pocket yet more powerful than that which brought the astronauts back from the moon 50 years ago is occurring across the medical crafts.

Through your AMA Council of Public Hospital Doctors (AMACPHD), combined with the contribution of your AMA Council of General Practice, we will be developing our position on the transformational implications of Artificial Intelligence (AI), new technology(s) and robotic machines for the AMA Federal Council endorsement along with our recommendations about AI etcetera's implications for doctors' practice of hands-on medicine and the structure of doctors' workplaces. This contemporary AMA response will emphasise that AI etcetera is always an adjunct to human decision making and goals and provide guidance to the medical workforce and employing organisations about work implications that the changes are likely to bring.

The AMA National Conference May 25, 2019 session Artificial Intelligence in Health Care considered the reality of AI and related technologies. I was persuaded that there are virtually limitless effects coming our way, all of which are mighty expensive, so I don't know when they will arrive. At the very least, AI at some point will change clinical decision-making processes, and disease detection, and will "mainstream IT" and machines for surgery assistance, precision medicines development, and remote patient monitoring. Even health administrative and management systems will not escape the reach of change in specific areas of, for example, patient triage, workforce planning and resource allocation. The activities of public health will also be facilitated to become 24/7 (potentially with greater efficiency, accuracy and cost-effectiveness but watch out for the associated terms and conditions employers may want to unfairly press onto us).

To paraphrase one of our AMACPHD members, following debate on these matters during our 15 July 2019 meeting, four thoughtful fundamentals of which the profession must take heed were conveyed:

- be alert – new technologies are coming, will affect your life, and will be disruptive;
- be cautious – new technologies aren't always successful, don't always deliver as promised and may actually (and expensively) fail;
- be optimistically sceptical – ensure that your workload and importantly that of others actually reduces and doesn't increase; and
- be guarded – that new technologies do not impinge on doctors' privacy or time off.

Now in its third iteration, sadly changing more slowly than some technological changes themselves, the AMACPHD policy document we are working to finalise (with AMACGP assistance) aims to frame the AMA's values about human aspects of care not being degraded and professional autonomy, clinical independence, career paths and training models not being undermined.

Also, from a medical workplace perspective, we aim to highlight the importance of all of us being upskilled to integrate and use new technology for our patients' and our own benefit, and concurrently ensure we are properly engaged by decision-makers about the sensible and safe implementation, integration and appropriateness of AI etcetera. Also, key are Members' industrial rights and conditions that fairly remunerate new ways of working, ensure we are involved in employer-led change and protect us against de-skilling, fatigue and exploitation.

The introduction of new technologies will likely change the way all medical practitioners interact with patients, how we undertake clinical assessments and make therapeutic or diagnostic recommendations, conduct certain treatments and procedures, manage administrative tasks, deliver health services and more.

Your AMACPHD, along with you, the Member, are being asked to grapple with very rapid advancements that produce cumulative effects and unpredictable change. So, while there are many perceivable potential benefits of such change, I am all too conscious of the many pitfalls we must identify early and resist. In response, our finalised AMA position statement will need to be comprehensive but simultaneously nimble; perhaps a perfect job for AI to help design.

Research

WITH CHRIS JOHNSON

Snacking looks good for night workers' health and performance

There are 1.4 million shiftworkers in Australia and all of them eat at irregular hours.

A new research study by the University of South Australia has investigated whether altering food intake during a nightshift could reduce sleepiness and optimise how shiftworkers feel during the night.

Researchers tested the impact of either a snack, a meal, or no food at all, and found that a simple snack was the best choice for maximising alertness and productivity.

Lead researcher and UniSA PhD candidate Charlotte Gupta said the finding had the potential to help thousands of night workers.

"In today's 24/7 economy, working the nightshift is increasingly common, with many industries – health care, aviation, transport and mining – requiring employees to work around the clock," Ms Gupta said.

"As a nightshift worker, finding ways to manage your alertness when your body is naturally primed for sleep can be really challenging.

"We know that many nightshift workers eat on-shift to help them stay awake. But, until now, no research has shown whether this is good or bad for their health and performance.

"This is the first study to investigate how workers feel and perform after eating different amounts of food.

"The findings will inform the most strategic eating patterns on-shift and can hopefully contribute to more alert and better performing workers."

In Australia, of the 1.4 million shiftworkers, 15 per cent (more than 200,000) regularly work a night or evening shift. Working at night-time conflicts with a person's internal circadian clock, making it harder to stay focused and awake.

Managing fatigue is therefore critical for workplace health and safety, the authors state.

Research

Over a seven-day simulated shiftwork protocol, the study assessed the impact of three eating conditions – a meal comprising 30 per cent of energy intake over a 24-hour period (for example, a sandwich, muesli bar, and apple); a snack comprising 10 percent of energy intake (for example, just the muesli bar and apple); and no food intake at all – each consumed at 12:30 am. The 44 participants were randomly split into the three test-conditions and were asked to report on their levels of hunger, gut reaction and sleepiness.

The results showed that while all participants reported increased sleepiness and fatigue, and decreased vigour across the nightshift, consuming a snack reduces the impact of these feelings more so than a meal or no food at all. The snack group also reported having no uncomfortable feelings of fullness as noted by the meal group.

Ms Gupta said the next step in the research is to investigate the different types of snacks and how they affect shiftworkers differently.

“Now that we know that consuming a snack on nightshift will optimise your alertness and performance without any adverse effects, we’re keen to delve more into the types of snacks shiftworkers are eating,” she said.

“Lots of shiftworkers snack multiple times over a nightshift, and understanding the different macronutrient balances is important, especially as many report consuming foods high in fat, such as chips, chocolate and fast foods.

“We’re keen to assess how people feel and perform after a healthy snack versus a less-healthy, but potentially more satisfying snack like chocolate or lollies.

“Ultimately, the goal is to help Australian shiftworkers on the nightshift to stay alert, be safe, and feel healthy.”

The study can be found at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6628383/

Artificial intelligence and aneurysm diagnosis

Macquarie University is collaborating on a research program aimed at improving brain aneurysm diagnoses. The project is focused on developing a solution that leverages artificial intelligence (AI) to detect and monitor brain aneurysms on scans faster and more efficiently.

The project has received a Cooperative Research Centres Projects (CRC-P) grant of AU$2.1M from the Department of Industry, Innovation and Science.

Macquarie University and Macquarie Medical Imaging, along with Fujitsu Australia and GE Healthcare, have partnered in the research.

Brain aneurysms, a common disorder caused by a weakness in the wall of a brain artery, are present in between two and eight per cent of adults, with multiple aneurysms in more than 10 per cent of these people. Rupture of an aneurysm causes brain haemorrhage in 85 per cent of cases, leading to death in 30-40 per cent of people and 20 per cent permanent disability in those who survive.

Fujitsu will lead the initiative and leverage its AI and digital solutions capability through its dedicated innovation team in Australia. GE Healthcare will contribute through its leading medical imaging technology. Macquarie University and Macquarie Medical Imaging will provide clinical expertise for the development and testing of the technology. Initially the project will focus on refining the technology with a view to creating a fully commercialised solution that will be distributed initially through radiology practices in Australia and eventually on a worldwide basis.

Professor John Magnussen, Diagnostic and Interventional Radiologist at Macquarie Medical Imaging, said: “This is an amazing opportunity to be able to address the problem of the rapid and accurate diagnosis of brain aneurysms. Even in ideal circumstances, detecting brain aneurysms is time and expertise intensive and missed aneurysms can have terrible outcomes. By creating an AI assistant to automatically flag potential aneurysms and allow for accurate follow-up, we can make a huge difference to patient care.”

Professor Patrick McNeil, Deputy Vice Chancellor Medicine and Health at Macquarie University, said: “This is an excellent example of the MQ Health model of Heal, Learn and Discover in action with industry. Macquarie University, with its own hospital and clinical expertise is well placed to actively contribute to the development of applied medical innovations.”

As a part of the project, Fujitsu will apply AI methods to images of the brain generated by GE’s Revolution CT scanner, and use a specifically-trained algorithm to look for abnormalities and aneurysms.

Research

Outcomes from this project are anticipated to include the development and validation of an AI algorithm capable of highlighting blood vessels within the circle of Willis, an arterial ring sited at the base of the brain, that may have one or more aneurysms. This technology will also allow the tracking of identified aneurysms over time, providing radiologists with a valuable diagnostic support tool and patients with greater peace of mind that known aneurysms are being effectively monitored over the long term.

A second element to the project will include a planning tool for surgical (stent) intervention. This tool will use fluid dynamic modelling to predict the risk of aneurysm rupture.

Helping PNG fight leprosy protects Australia too

Combating leprosy in Papua New Guinea will protect Far North Queensland from the possible spread of the rarely-acquired disease and other infectious disease, according to research published in the *Medical Journal of Australia*.

Leprosy, an infection caused by *Mycobacterium leprae*, is endemic in Papua New Guinea (PNG), with 388 new cases notified in 2015, and the annual number changing little over the past decade.

The authors of the research, led by Dr Alison Hempenstall, a registrar based at Thursday Island Hospital, reviewed all laboratory-confirmed cases diagnosed in FNQ between 1989 and 2018. They aimed to determine if the ongoing transmission of leprosy in PNG had had any impact on Australians.

“Since 1985, Torres Strait Islander Australians and PNG nationals have been able to move freely across the border to pursue traditional activities in the Torres Strait Protected Zone,” Dr Hempenstall and colleagues wrote.

“This arrangement acknowledges the importance of their shared cultural history, but the potential public health implications are also clear.”

There were 20 cases of leprosy recorded in the Queensland Health Notifiable Conditions Register during the study period; 11 patients were born in Australia, including seven Torres Strait Islanders. There were no cases among Aboriginal Australians. A 28-year old Torres Strait Islander woman diagnosed in 2009 was the most recent Australian-born case; she had had close contact with a person with leprosy born in PNG.

“However, while there has been no case of locally acquired leprosy since 2009, two PNG-born Torres Strait Islanders have been diagnosed with the disease in the past decade. The continuous flow of people between Australia and PNG makes ongoing vigilance essential,” the researchers state.

Australia will provide an estimated $608 million in development assistance to PNG during 2019–20, the authors said, with some of that going towards the public health system and NGOs involved in containing leprosy.

“However, more could be done,” Dr Hempenstall concluded.

“Leprosy is a disabling and infectious condition that can be rapidly cured. Public health programs have dramatically reduced the burden of infectious diseases in Australia. Greater support for similar programs in PNG will not only help our nearest neighbours, but will also reduce the risk of reappearance of infectious diseases – like leprosy – that have been almost forgotten by Australians.”

Study finds new fathers feel shut out of health system

A Flinders University study has found that new fathers often feel disengaged from the healthcare system and let down by healthcare professionals.

First-time fathers can feel alone, disempowered and even belittled by the system, including in their engagement with healthcare professionals, the research report warns.

Research

Breaking down barriers for new fathers to feel more at ease in their life-changing role will help them reach full potential.

"Fathers need tailored support to be better equipped to provide the support they want and need to become the best they can be to their partners and new baby," Flinders University mental health researcher Dr Anthony Venning said.

"Effectively targeting men with well-designed interventions has the ability to improve not only paternal outcomes, but those for the child and mother.

"With a small change of focus and more inclusive approaches, this can the best experience of their lives."

Co-parenting techniques, covering father involvement in feeding, settling baby and attending appointments, can develop more seamlessly if fathers are made to feel comfortable and involved in parenting programs.

The study found that other support systems are needed in the lead-up to and after the arrival of a baby. These include:

- Services accessible outside of business hours or via phone or online methods have the potential to reach more fathers and overcome barriers to engagement such as stigma, masculinity, fatigue and time restraints.
- Perinatal services and parenting resources need to promote themselves and be inclusive of fathers of new children, particularly given the tendency of fathers to 'wing it' and only seek information in a reactive manner.
- Social support networks by baby-friendly communities to facilitate fathers' role, particularly for stay-at-home-dads.
- Mix face-to-face support from family doctors, midwives and community nurses with more informal, interactive resources using positive father role models.
- Make fathers feel more informed and knowledgeable about practical matters, including infant crying, postpartum depression and partner wellbeing, breastfeeding, so they do not feel like a secondary 'shadow in the room' but actively and well-connected players in their parenting role.

The report, prepared in collaboration with the South Australian Mental Health Commission, aims to build an evidence base to develop strategies to support new fathers and their families. It concludes that the perinatal period is a 'teachable moment' that can be fully harnessed to support the mental health and wellbeing needs of new fathers.

Larger-scale, longitudinal studies are required to investigate the usefulness of current systems and interventions.

"Our study aims to inspire more work and investigation into engaging fathers to be 'supportive and involved' in their family unit," Dr Venning said.

AMR threat to Australia

The global rise of antimicrobial resistance presents unique threats to Australia, and a black hole in surveillance, according to research published in the *Medical Journal of Australia*.

It highlighs the need to implement nimble, cross-sectoral and collaborative systems that are fit for purpose in the 21st century.

"While a high level of health care is enjoyed by most Australians, there is currently a large reservoir of antimicrobial resistance (AMR) both within Australia and at our doorstep," Associate Professor Deborah Williamson, Deputy Director of the Microbiological Diagnostic Unit Public Health Laboratory and colleagues said.

The study's authors described four pathogens that are highly resistant, and emerging, but are not yet endemic in Australian health care and community settings.

Those threats are:

- carbapenemase-producing *Enterobacteriales* (CPE): resistant to carbapenems and a range of other antimicrobials, limiting treatment options to one or two less efficacious (and often more toxic) alternatives — or in some cases, no alternatives. Mortality rates of about 40 per cent have been reported for infections caused by CPE, making these pathogens a critical public health threat. The number of CPE reported in Australia increased from 527 in 2017 to 603 in 2018, a relative change of 14.4 per cent;
- *Candida auris*, a yeast: high crude mortality rates associated with invasive infections (up to 50 per cent); resistance to several antifungals, particularly triazole antifungals and amphotericin B; difficulties in laboratory identification; and widespread patient-to-patient transmission, facilitated by environmental contamination. *C. auris* in Australia has been associated with overseas acquisition however ongoing vigilance, including screening of patients with recent exposure to overseas health care facilities, is required to prevent endemicity in Australia.
- drug-resistant typhoid from a Pakistan province, and thought to be acquired from *Escherichia coli.* To date, no outbreak-associated cases have been formally reported in Australia, although cases have been reported in the United Kingdom and the United States. The report states it is imperative

Research

that travellers to Pakistan and clinicians treating patients returning from this region are aware of these heightened health risks; and

- *N. gonorrhoeae,* resistant to the two dual first line treatments, ceftriaxone and azithromycin. Between February and April 2018, three cases of extensively drug-resistant N. gonorrhoeae were described: one in the UK and two epidemiologically unrelated cases in Australia. All three isolates were highly related, suggesting circulation of this clone in South-East Asia. "In the face of dramatically increasing gonorrhoea notifications in Australia (from 66.9 to 125.9 notifications per 100 000 population in 2014 and 2018, respectively), a concerted national effort is required ... including reducing the number of circulating cases, as spread of AMR is directly proportional to prevalence," the report states.

"Advances in genomic technology provide unparalleled opportunities to move existing surveillance systems beyond number-counting, and enable real-time information on the relatedness of hospital and community-associated AMR pathogens across jurisdictions," Professor Williamson and colleagues wrote.

"However, there is presently no formal national mechanism for rapid, real-time sharing and analysis of AMR-related genomic and epidemiological data across [Australian] jurisdictions, creating a major risk for successful implementation of one of the pillars of the 2015–2019 National Antimicrobial Resistance Strategy — the development of nationally coordinated One Health surveillance of AMR."

According to the report, laboratories are shooting themselves in the foot.

"The widespread adoption of culture-independent diagnostic testing for many pathogens (eg, *N. gonorrhoeae, Salmonella spp., Shigella spp.*) hampers the ability of laboratories to detect AMR in these pathogens, creating a black hole in AMR surveillance," they wrote.

"As strategies are put in place internationally (including the use of real-time genomic surveillance) to effectively prevent, detect and treat AMR pathogens, it is critical that Australia also implement nimble, cross-sectoral and collaborative systems that are fit for purpose in the 21st century."

INFORMATION FOR MEMBERS

Australian Government
Department of Health
Therapeutic Goods Administration

Seeking members for TGA's statutory advisory committees

Would you like to contribute to the regulation of therapeutic goods in Australia? Have you considered becoming a member of a TGA statutory advisory committee?

The TGA is seeking applications from scientific and technical experts to fill a number of upcoming vacancies on TGA's statutory advisory committees. You must have expertise in relevant clinical or scientific fields or experience with consumer health issues.

As a committee member you will contribute significantly towards the TGA's regulatory functions by providing independent expert advice on matters across a broad spectrum of issues relating to medicines, devices, cell and tissue products and other products and substances.

Further information about the role of TGA's statutory advisory committees is available at

https://www.tga.gov.au/tga-statutory-advisory-committees

If you have the appropriate expertise and are interested in contributing to the regulation of therapeutic goods in Australia, we would like to hear from you. The deadline for applications is close of business **27 August 2019**.

To apply, and find out more about the appointment process, go to:

https://www.tga.gov.au/statutory-advisory-committee-vacancies

World News

WITH CHRIS JOHNSON

WMA condemns arrest of Turkish health professionals

The arrest of four Turkish health professionals for providing medical care to a wounded child in Turkey during a curfew has been deplored by the World Medical Association (WMA) and the Standing Committee of European Doctors (CPME).

The four health staff – a physician Dr Nesim Sayın and three nurses – were detained and arrested by Turkish authorities early in August, following a police raid on their homes.

According to information from their lawyers, they provided care to a 12-year-old wounded child in 2015 at a time when there was a curfew and access to health services was almost impossible. They have now been detained in Şırnak Prison on charges of providing support to terrorist activity.

Dr Frank Ulrich Montgomery, Chair of the WMA and CPME President, wrote directly to the Turkish President to protest about "the brutal arrest" of the four.

"There is a remarkable disproportionality between the alleged facts and the measures taken by the Turkish authorities. We are very sceptical that providing care to a 12-year-old wounded child constitutes a crime that poses a threat to public order justifying such a police raid," he said.

"These health professionals have done nothing more than perform their duties in line with the ethical principles of health care. According to our code of conduct, it is a physician's obligation to maintain the utmost respect for human life. It is therefore our responsibility to extend health care to all who need it, anywhere and even in emergency situations.

"Penalising those providing health care to injured people is an aberration and a flagrant infringement of medical ethics, humanitarian and human rights.

"International humanitarian law, ratified by Turkey, requires health professionals to provide health care and assistance to all in need and in all circumstances. To criminalise these actions is appalling.

"We urge the Turkish authorities to recognise this fact and to immediately drop the charges and release these health professionals."

World News

Ebola may now be curable with two new drugs

Scientists have announced two new experimental treatments for Ebola that they say will significantly help contain the outbreak of the deadly disease in eastern Congo.

In fact, reports are going so far as to say that Ebola should no longer be regarded as incurable.

The *Washington Post* reports that the drugs have been tested in a nearly nine-month clinical trial and have performed so well that health professionals will now administer them to every patient in Congo.

Jean-Jacques Muyembe Tamfum, a Congolese doctor who has spent his career researching Ebola treatments and oversaw the trial on the ground, told a news conference that he could not have imagined such a day would come.

"From now on, we will no longer say that Ebola is incurable," he said.

And the *Washington Post* quotes Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, saying: "It's the first example that a therapeutic intervention can have a dramatic effect on decreasing the mortality of the Ebola virus disease."

He said medical professionals on the ground in Congo have sufficient stores of both drugs to administer them to all infected people.

"This underscores the importance of doing randomised, controlled trials. You can get ethically sound and scientifically sound information rapidly," he said.

According to the *Post* report, the two new therapies were tested in a multi-drug, controlled trial since November last year. Researchers administered one of four drugs to patients who had participated in the study, and when a monitoring group they noticed that two of those drugs were vastly outperforming the others.

The scientists then called off the study to exclusively treat Ebola patients with the more effective drugs.

The two antibody-based treatments are known as REGN-EB3 and mAb-114 and are administered once intravenously as soon as possible after infection. The drugs are proving to be effective because they appear to block a protein critical to the Ebola virus.

Preliminary data from the trial shows doctors saving about 90 per cent of patients with low levels of infection. Across all levels of infection, patients who received REGN-EB3 had a mortality rate of 29 per cent, while those treated with mAb-114 had a mortality rate of 34 per cent, the *Post* reports.

The average mortality rate for Ebola has been about 50 per cent, according to the World Health Organisation. All Ebola patients will now receive one of the two more effective drugs.

The vital next step, however, is to overcome the suspicion of health workers in Ebola affected regions. Violence continues to mar the efforts of vaccination providers trying to contain the spread of Ebola, as political unrest, armed conflict, and social upheaval spreads across eastern Congo. More than 200 health professionals have been attacked since January this year, with several being killed.

"The success is clear, but there is also a tragedy linked to this success, and the tragedy is that not enough people are being treated," said Michael J. Ryan, executive director of the WHO Health Emergencies Program.

"We are still seeing too many people stay away from Ebola treatment units, too many people not coming to hospitals are not being found in time to benefit from these therapies."

World News

Commitment to help wipe out TB in Asia Pacific

Australian has committed $13 million towards global efforts in eradicating tuberculosis in South-East Asia and the Pacific region.

TB is the world's most common cause of death from a single infectious disease, and tenth most common cause of death worldwide.

The World Health Organisation estimates that about 10 million people each year fall sick with TB, with nearly 60 per cent of new cases each year occurring in the Indo-Pacific region.

Australia's Foreign Minister Marise Payne said the health, prosperity and resilience of Australia and countries in our neighbourhood are deeply intertwined.

"The Government will provide $5 million to support intensive TB detection and treatment under Australia's Health Security Initiative for the Indo-Pacific region," she said.

"We will help build a skilled workforce to detect the disease, improve the quality of TB surveillance, make sure people stick to their treatment and work with partner governments in the region to develop and implement evidence-based TB elimination strategies."

Health Minister Greg Hunt said the Medical Research Future Fund will also be used provide $8 million to fund anti-microbial resistance and drug-resistant TB research projects.

"The projects will be undertaken by Australian universities or medical research institutes collaborating with researchers in Pacific island countries," he said.

"The Government is committed to helping address the health and human security needs of our region to better protect the health of all our citizens. Health is an example of how Australia and our Pacific neighbours face common challenges and benefit from working together."

The key focus of the initiative is to enable research on anti-microbial resistance and drug-resistant TB to:

- develop strategies that improve outcomes for individuals and the community;
- build collaboration between Australia and Pacific island countries; and
- transfer knowledge and capability to Pacific island countries to support workforce development.

Australia will make its highest ever contribution to Pacific development in 2019-2020, with an estimated $1.4 billion in development assistance to address issues of greatest concern.

INFORMATION FOR MEMBERS

AMA Fees List – 1 September 2019 Changes

The 1 September 2019 changes to the AMA Fees List will be available soon from FeesList Online: https://feeslist.ama.com.au/

The changes cover all amendments to the Medicare Benefit Schedule since December 2018 up until July 2019.

If you wish to know what these changes will be prior to 1 September 2019, the PDF and CSV versions of the AMA Fees List will be updated on 15 August 2019.

To access the AMA Feeslist Online, members require a Federal AMA website account username and password.

To set up your login details, please contact Member Services on 1300 133 655 or by email memberservices@ama.com.au

Once you are on FeesList Online you can download the CSV and PDF files plus access a range of handy database features including:

- Interactive search function that links AMA items to the MBS codes online.
- Personalised account to save your favourite AMA items, pages and sections.
- Online fee calculators such as the anaesthesia fee calculator.
- Helpful tutorials and information along the way.

For more information on the Fees List, contact feeslist@ama.com.au

World News

Progress made by some countries in fight against tobacco

The World Health Organisation's seventh report on the global tobacco epidemic shows that while many governments around the world are making progress with helping their citizens quit smoking, there are still too many countries with few or inadequate anti-tobacco measures in place.

About five billion people today live in countries that have introduced smoking bans, graphic warnings on packaging and other effective tobacco control measures, which is four times more people than a decade ago, the report says. But some countries are still not implementing lifesaving policies to help people quit tobacco.

The recently-released WHO Report analyses national efforts to implement the most effective measures from the WHO Framework Convention on Tobacco Control (WHO FCTC) that are proven to reduce demand for tobacco.

These measures, like the "MPOWER" interventions, have been shown to save lives and reduce costs from averted healthcare

World News

Progress made by some countries in fight against tobacco... continued

expenditure. The MPOWER report was launched in 2007 to promote government action on six tobacco control strategies in-line with the WHO FCTC to:

- Monitor tobacco use and prevention policies.
- Protect people from tobacco smoke.
- Offer help to quit tobacco use.
- Warn people about the dangers of tobacco.
- Enforce bans on tobacco advertising, promotion and sponsorship.
- Raise taxes on tobacco.

The focus of the latest report is on the progress countries have made to help tobacco users quit. It was launched in Brazil, a country that has become the second, after Turkey, to fully implement all the MPOWER measures at the highest level of achievement.

WHO Director-General, Dr Tedros Adhanom Ghebreyesus, said governments should implement cessation services as part of efforts to ensure universal health coverage for their citizens.

"Quitting tobacco is one of the best things any person can do for their own health," Dr Tedros said.

"The MPOWER package gives governments the practical tools to help people kick the habit, adding years to their life and life to their years."

Progress is being made, with 2.4 billion people living in countries now providing comprehensive cessation services (2 billion more than in 2007). But only 23 countries are providing cessation services at the best-practice level, making it the most under-implemented MPOWER measure in terms of number of countries offering full coverage.

Tobacco cessation services include national toll-free quit lines, services to reach larger populations via mobile phones, counselling by primary health care providers and cost-covered nicotine replacement therapy.

Michael R. Bloomberg, WHO Global Ambassador for Noncommunicable Diseases and Injuries and founder of Bloomberg Philanthropies, said the report shows government-led efforts to help people quit tobacco work when properly implemented.

"More countries are making tobacco control a priority and saving lives, but there's still much more work to be done," Mr Bloomberg said.

"The WHO's new report shines a spotlight on global efforts to help people quit using tobacco and it details some of our most important gains."

The report, funded by Bloomberg Philanthropies, showed that while only 23 countries have implemented cessation support policies at the highest level, 116 more provide fully or partially cost-covered services in some or most health facilities, and another 32 offer services but do not cost-cover them, demonstrating a high level of public demand for support to quit.

Tobacco use has also declined proportionately in most countries, but population growth means the total number of people using tobacco has remained stubbornly high. Currently, there are an estimated 1.1 billion smokers, with about 80 per cent of them live in low- and middle-income countries.

The last report was issued in 2017. Since then, 36 countries have introduced one or more MPOWER measures at the highest level of achievement.

In Andorra, Australia, Brazil, Colombia, Egypt, Mauritius, Montenegro, New Zealand, North Macedonia and Thailand, taxes have been set to comprise at least 75 per cent of tobacco retail prices.

World News

American doctors talk about racism and child health

The American Academy of Pediatrics has released its first ever policy statement on how racism affects the health and development of children and adolescents, saying racism is a significant social determinant of health clearly prevalent in society.

The Academy is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Its statement, *The Impact of Racism on Child and Adolescent Health*, says racism is having a profound impact on the health status of children, adolescents, emerging adults, and their families.

It says the impact of bias on the health of children is even starting before they are born, with poverty and poorer medical care affecting birth weights and health conditions in some minority groups.

"Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear," the report states.

"Failure to address racism will continue to undermine health equity for all children, adolescents, emerging adults, and their families."

The statement stresses that the social environment in which children are raised shapes child and adolescent development, and pediatricians are poised to prevent and respond to environmental circumstances that undermine child health.

"The impact of racism has been linked to birth disparities and mental health problems in children and adolescents," it states.

"The biological mechanism that emerges from chronic stress leads to increased and prolonged levels of exposure to stress hormones and oxidative stress at the cellular level.

"Prolonged exposure to stress hormones, such as cortisol, leads to inflammatory reactions that predispose individuals to chronic disease. As an example, racial disparities in the infant mortality rate remain, and the complications of low birth weight have been associated with perceived racial discrimination and maternal stress."

The Academy looks to its own profession for action and even suggests some health practitioners might need to examine their own prejudices.

"Pediatricians and other child health professionals must be prepared to discuss and counsel families of all races on the effects of exposure to racism as victims, bystanders, and perpetrators," the report states.

"Pediatricians can implement systems in their practices that ensure that all patients and families know that they are welcome, that they will be treated with mutual respect, and that high-quality care will be delivered regardless of background using the tenets of family- and patient-centered care.

"To do this, it is critical for pediatricians to examine their own biases. Pediatricians can advocate for community initiatives and collaborate with government and community-based organisations to help redress biases and inequities in the health, justice, and educational systems. These strategies may optimise developmental outcomes and reduce exposure to adverse events that dramatically alter the lived experiences, health, and perceived self-value of youth."

The policy statement can be found at:

https://pediatrics.aappublications.org/content/144/2/e20191765

Fifty years on and it remains a highlight

BY CHRIS JOHNSON

A lot happened in the history of the world 50 years ago.

In July 1969, Neil Armstrong and Buzz Aldrin stepped foot on the moon. Pretty impressive.

A month later, almost half a million hippies stomped their feet in the mud of a 600-acre farm in Bethel, New York.

Jimi Hendrix stepped foot on a purpose-built stage there. Thirty-two acts in total played in what was billed as "3 Days of Peace & Music" at the Woodstock Music Festival.

Armstrong and Aldrin made it back from the moon in time to attend Woodstock, but there is no record of them being there. Might have been a little anticlimactic for them.

One man who did attend, and who still has the original Woodstock program and flyer, is a retired scientist from St Louis who has called Australia home for the past 40 years.

Joe Swartz was 28 at the time of the Woodstock festival and was in his final year of an elementary particles physics doctorate at New York's Cornell University.

That was just a couple of hundred kilometres from the farm southwest of Woodstock.

He describes the event as a definite highlight of his life, but says it wasn't all fun.

He told his story to *Australian Medicine*.

"About ten miles from home the traffic was already backed up. From there it was just sort of climbing over cars to get in," he says.

"There were times when it was actually depressing because it was overwhelming and yet very lonesome, and the conditions were really bad.

"We got there on Friday and managed to get in and pitch a tent on the site. But that night it rained, and I woke up lying in water because I had actually pitched the tent partly on a roll of barbed wire.

"So we left that site on the Saturday morning and never went back to it. I went with another guy but after that first night I never saw him again. You never saw anyone more than once. It was so massive.

"Another guy who was bringing all our food and beer didn't make it. So we had no food either. I lost my shoes too because it was muddy come Saturday and you just left your shoes behind in the mud. And I'm walking around cold and wet and muddy and hungry, and starting to feel down. But then Saturday night there was this pick up.

"What got me out of the downs was when Sly and the Family Stone came on stage and sang *Higher and Higher*. That woke you up and it picked me up. Following on from that, in regards to keeping me feeling good – were people like Janis Joplin; Jefferson Airplane; Crosby Stills Nash and Young, all one after the other. It just kept getting better and better and better. I was there the whole time and saw almost everybody.

Dr Joe Swartz with his original Woodstock program

"The Who played Tommy as the sun rose. It was all incredible music. Helicopters started dropping food parcels and you'd run up and grab one. That kept us going.

"I didn't see any debauchery. There wasn't really any of that. Even the drug stuff was largely beat up. There was marijuana around, but I never saw anything harder ... maybe that was just with the musicians. But I wasn't part of the young crowd really. A lot of people there were a lot younger than me.

"One thing I really remember most was when Jimi Hendrix hit that really loud stuff on the guitar in *Star Spangled Banner*. Wow. I walked to the right spot in the middle just to get a good view of him.

"Hendrix was on last, on the Monday morning. When he finished playing it was over. He was supposed to close it all down on Sunday night, but it ran late and he chose to play Monday morning.

"After he played, I went around the back and there was a fence behind the stage and a caravan that was some sort of control centre. Hendrix came out and he went into the caravan to listen to some of his gig. Then he came out and saw someone near me on the fence who he knew, and he came up and started talking to them. I was right there.

"It is all a great memory and has stayed with me my whole life. And it was all part of the times. The war was going on and the civil rights movement was in full swing. It was actually a relief from it all."

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.

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.

AMA