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Dispensing in general practice

Time to look at new pharmacy rules, p3

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AMA LEADERSHIP TEAM

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Dr Tony Bartone

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In this issue

Allow pharmacists to dispense from general practice

Doctor ownership of pharmacies dispensing from general practice is a model the AMA wants the Federal Government to consider.

Such a model follows world's best practice and enhances patient convenience and access.

"It's also about improving health outcomes," said AMA President Dr Tony Bartone.

"And that's what the evidence has shown right around the world, when all members of a healthcare team work in collaboration together with the patient, with their file, with their records, with their history all together in the one location.

"It's what happens now in a ward round in hospital, where you get all the team members coming around, doing the ward round. The pharmacist is a member of that team. That's not what happens in the community."

To this end, the AMA has formed a new General Practice Pharmacy Working Group to drive policy, strategy, and advocacy on pharmacy and dispensing, and to provide the Government with strategic AMA general practice input to the Seventh Community Pharmacy Agreement.

Allow pharmacists to dispense from general practice ...continued from p3

The Working Group was created following an urgency motion passed at the last meeting of the AMA Federal Council.

> "The new Working Group will consult with the AMA Council of General Practice to develop an advocacy blueprint on new dispensing models."

Dr Bartone said the community was missing out because of archaic pharmacy ownership rules and pharmacy location rules.

"Evidence would suggest that this is the last remaining cartel in the community that needs to be looked at in terms of anti-competitive practices," Dr Bartone told 3AW.

"Many eminent economists and regulators have suggested that it's time to remove the restriction on pharmacy ownership and co-location rules... The patients and members of the community are missing out and they're left suffering with lack of access to more competitive practices and the convenience and access. So, I'd suggest that at the moment it might be changing."

The new Working Group will consult with the AMA Council of General Practice to develop an advocacy blueprint on new dispensing models.

Currently, some pharmacists are working as non-dispensing pharmacists in general practice. Known as GP pharmacists, they cannot dispense.

Dr Bartone said it was time to consider taking it to the next level.

"The AMA has long called for the Commonwealth pharmacy regulations to be amended to enable pharmacies and medical practices to be co-located," he said.

"The AMA supports high-quality primary health care services that are convenient to patients, enhance patient access, and improve collaboration between health care professionals.

"Co-location of medical and pharmacy services would clearly facilitate this.

"The AMA also wants to see State and Territory pharmacy regulations changed to allow broader ownership of pharmacy businesses. The AMA wants to see an end to pharmacies only being owned by pharmacists.

"Incorporating pharmacy services into general practice, under the ownership of a medical practitioner, would improve patient care by allowing GPs to lead a team of co-located health professionals in providing multidisciplinary health care to patients at the local community level.

"Many general practices already provide co-located services with pathology collection centres, and in-house psychologists, physiotherapists, dieticians, and podiatrists. Adding pharmacy to the mix would have benefits for patients, pharmacists, and GPs."

With negotiations for the Seventh Pharmacy Agreement now underway, there is an opportunity for the AMA to inform the Government how it could increase competition in the pharmacy space, provide pharmacists with improved opportunities for working to their scope of practice within general practice, and safely deliver patients more convenient access to prescribed medicines.

"It is important that all key stakeholders have input to the next Pharmacy Agreement," Dr Bartone said.

The AMA Federal Council's urgency motion reads:

> *Federal Council resolves to form a General Practice Pharmacy Working Group which will consult with AMACGP to develop an advocacy blueprint for the next Federal Council meeting regarding new dispensing models, including doctor ownership of pharmacies dispensing from general practice, which will offer patients enhanced convenience, safety, and quality care in their access to medications.*

CHRIS JOHNSON

General practice leaders unite to condemn Pharmacy Guild's stunt

The leaders of Australia's peak general practice organisations have united to condemn attempts by the Pharmacy Guild of Australia to have pharmacists take over roles traditionally and expertly performed by GPs, including moves to have pharmacists prescribe some scheduled medications.

United General Practice Australia (UGPA) reached unanimous agreement at its recent meeting in Canberra to combine resources, including members spread across Australia, to convince governments to resist any attempts by the Pharmacy Guild to undermine and weaken quality primary health care in Australia.

AMA President Dr Tony Bartone is also the Chair of UGPA. Speaking on behalf of the group, Dr Bartone said patient safety should not be put at risk by the Guild's relentless push to increase pharmacy profits.

"The Pharmacy Guild must be stopped in its attempts to bully governments into allowing pharmacists to take over the work of doctors," Dr Bartone said.

"Pharmacists are highly valued members of the health workforce who work well in partnership at the community level with local GPs – but they do not have the skills, expertise, or many years of highly-specialised training to perform the work of GPs.

"Access does not equate to quality care, and these skills are required even when issuing a repeat prescription. UGPA's focus is on the provision of safe, quality medical and health care and advice for the community.

"The Guild should focus on advocating for its members and for local community pharmacists, not engaging in petty turf wars to increase profits for its pharmacy owner members.

"This proposal by the Pharmacy Guild flies in the face of the safety standards, even as set out in their own guidelines, in relation to the separation of prescribing and dispensing."

Dr Adam Coltzau, President of the Rural Doctors Association of Australia (RDAA), said the Guild was spreading misinformation about poor access to doctors in rural and remote areas.

"The Guild's dishonest claims that supposed reduced access to doctors in rural and remote areas could be addressed by increasing the scope of pharmacy practice are factually incorrect," Dr Coltzau said.

"There are very few rural towns that have a pharmacy and no doctor. And in smaller rural towns, pharmacies are rarely open after hours, or for any significant time over a weekend.

"Medical practices, even those in rural areas, quarantine appointments for urgent matters each day, and patients are able to take advantage of this service if they need a prescription quickly.

"We understand that running a profitable business in a rural town can be more challenging than in the city, but expanding the pharmacist role into clinical areas in which they aren't safe to operate is no way to address it. It just puts patients at risk."

Dr Ewen McPhee, President of the Australian College of Rural and Remote Medicine (ACRRM), said pharmacists working collaboratively with general practitioners was the best and safest model of care.

"Most doctors have a positive and productive relationship with their local pharmacist, and we respect each other's areas of expertise," Dr McPhee said.

"Pharmacists can offer a lot when it comes to the management of chronic and complex disease, and in the area of medication safety. A collaborative model where each member is working to their appropriate scope of practice,

rather than a fragmentation of care, is the way to achieve the best patient outcomes."

The UGPA leaders pledged to work with Federal and State governments to reject the overtures of the highly paid lobbyists employed by the Pharmacy Guild to put pharmacy profits ahead of patient safety.

UGPA is the broadest representation of general practice leaders in Australia, and comprises representatives from the AMA, RDAA, ACRRM, General Practice Supervisors Australia (GPSA), and the General Practice Registrars Australia (GPRA).

Health funds can't blame doctors for out-of-pockets

AMA President Dr Tony Bartone has called for health insurers to increase the rebates they pay to doctors in order to reduce gap payments.

He described the blaming of doctors for out-of-pocket costs as a devious ploy by private health funds to distract attention from their failure to pay adequate rebates for health care.

Dr Bartone's remarks follow reports from within the private health insurance sector suggesting doctors should be paid less in order to reduce gap payments.

Nib boss Mark Fitzgibbon said insurers should be able to guide their customers to doctors who charge a fair price.

But Dr Bartone said doctors' fees was not the problem. He said some insurers were only driven by their own profits.

Nib recently reported a 9.2 per cent lift in annual profit to $201.8 million.

"We know for a fact that the gaps occur because of, particularly, rebates from insurers, which have not kept pace with the cost of providing good quality care," Dr Bartone told Sky News.

"Now, what they're seeking to do here is to try and manage your care. That is, try and direct your care to the lowest common denominator .. from a price perspective ... that's all they're interested in.

"They're not interested in your care. They're not interested in the level of quality that you're getting. They just want to manage your care to a price and therefore continue to make the increasing profits.

"The gaps occur because those rebates have not kept pace with the cost of providing care and we know for a fact that if you compare funds, and you compare across the States and policies, those rebates vary considerably between the best and the least accommodating of the lot.

"So, blaming doctors for the gaps is really quite a devious ploy to try and distract from their attempt to try and manage your care.

"A lot of the cost, a lot of the surprise, is when you think that you're covered for something and you find out that you're not covered or that you're actually having to put your hand in the pocket for more than you thought."

In a separate interview with *The Australian*, Dr Bartone said many insurers were not paying a fair price for services.

"Some are not even coming close to covering the cost of providing that care," he said.

"That gap between the cost of provision of service and what they are paying is getting larger. That is what is creating the out-of-pocket gaps. If they were paying a fair fee, we wouldn't have that."

He said that up to 96 per cent of privately covered healthcare services had either no gap or a known gap, which he said was generally about $500.

Dr Bartone has stressed that private health insurance is a vital component of the nation's health system and that Australians wanted and deserved value cover from transparent policies and reputable health funds.

CHRIS JOHNSON AND MARIA HAWTHORNE

Hospital cover drops to 12-year low – APRA

Hospital cover has dropped to its lowest level in 12 years, with the percentage of Australians with basic cover continuing to plummet.

Only 44.2 per cent of the population has basic hospital cover, which is the lowest level since 2007 and a whole percentage point lower than the same time last year.

More than 28,000 Australians quit their policies in the three months from March this year.

The Australian Prudential Regulation Authority (APRA) recently released its latest data, showing health insurance premiums continuing to rise faster than wages.

Premiums rose almost 2.8 per cent over the June quarter.

Responding to the alarming figures, AMA President Dr Tony Bartone described the trend as highly concerning.

"This is a continuation of the same trend, the same spiralling down trend we've been referring to for many months now," Dr Bartone told the ABC.

"We need to address the issues underpinning this decline to ensure equity and access to the public health system.

"Our public health system is predicated on a specific amount of work being done on the private system — that is relieving a lot of pressure on public systems.

"If that was to fall over tomorrow, that would create an enormous burden, an enormous burden the public system could not cope with."

Australians pay an average of $315 in out-of-pocket expenses when they go to hospital.

The APRA report also found that out-of-pocket costs varied depending on location. Gap fees for specialists averaged $151, with Canberrans charged more (average gap fee of $271.40) and South Australians paying the least (average gap fee $69.37).

Health Minister Greg Hunt said the Federal Government was delivering "significant reforms" to private health insurance, making it simpler and more affordable.

"Work has already commenced with the healthcare sector to identify and implement the next wave of improvements for private health care," he said in a statement.

CHRIS JOHNSON

Gender Equity Summit Report

The report from the AMA Gender Equity Summit, which was held in Sydney earlier this year, is now available and participants are encouraged to embrace it.

The AMA is asking all organisations that attended the Summit to adopt and report on three immediate actions they will take as a result of the Summit to encourage and support equity within their sphere of influence.

The nine key action areas identified at the Summit are:

1. Establish targets for gender diversity in representation and leadership.
2. Report and publish gender equity data.
3. Actively encourage women to apply for leadership roles.
4. Provide equitable access to leave entitlements for all genders.
5. Improve access and uptake of parental leave and flexible work and training arrangements for all genders.
6. Provide interstate portability of leave entitlements.
7. Implement transparent selection criteria and processes that disarm gender bias in entry into training and employment.
8. Provide access to breastfeeding facilities and childcare at exams, conferences and work.
9. Identify gender equity champions (and celebrate women in medicine).

The AMA is committed to working collaboratively with other organisations who are dedicated to reducing bias and achieving diversity, equity and inclusion, for women and other underrepresented groups in the medical profession.

The Report will form the basis of practical actions and ongoing discussions that individuals, employers, training and professional bodies can pursue to make a real difference to achieving gender diversity, equity and inclusion in medicine.

The AMA is asking all organisations who attended the Summit to adopt and report on three actions from the Summit with the goal of encouraging and supporting gender diversity within their sphere of influence.

In 2019 the AMA has committed to:

1. Adopting a target of 40 per cent women, 40 per cent men, 20 per cent flexible for all AMA Councils, Committees and Boards, with a gender diversity target of women holding 50 per cent of Federal AMA representative positions overall, for attainment by 2021;
2. Collating and reporting on gender data annually regarding composition of leadership positions within State and Federal AMA bodies, Councils and Committees, speaker invitations at National Conference and Federal AMA recognition awards, and disseminating the findings to AMA Federal, State and Territory Councils and Boards annually;
3. Developing an AMA Diversity and Inclusion Plan, Including practical steps to improve diversity in membership and in the medical profession more broadly; and
4. Providing funding for breastfeeding mothers in Federal AMA representative roles to bring a carer for their child to official representative activities.

The full Gender Equity Summit Report 2019 can be downloaded from https://ama.com.au/ama-gender-equity-summit-report

Scene and heard

1. Dr Bartone meeting with Ian Yates, CEO of the Council on The Ageing.
2. Dr Bartone met with the Surgeon-General of the Australian Defence Force, Air Vice-Marshal Tracy Smart, and Commodore Sarah Sharkey from Joint Health Command.
3. Leading GP organisations gathered in Canberra as the United General Practice Australia. L-R: General Practice Registrars Australia CEO Dr Andrew Gosbell, Rural Doctors Association of Australia CEO Peta Rutherford, and Dr Bartone.
4. The AMA Board meeting at AMA House, Canberra. L-R: Dr Iain Dunlop, Dr Danielle McMullen, Dr Gary Speck, Dr Chris Zappala (Vice President), Dr Tony Bartone (President), A/Prof Gino Pecoraro (Chair), Dr Helen McArdle, A/Prof William Tam, A/Prof Rosanna Capolingua, Dr Bavahuna Manoharan. Apology: Dr Stephen Gourley.

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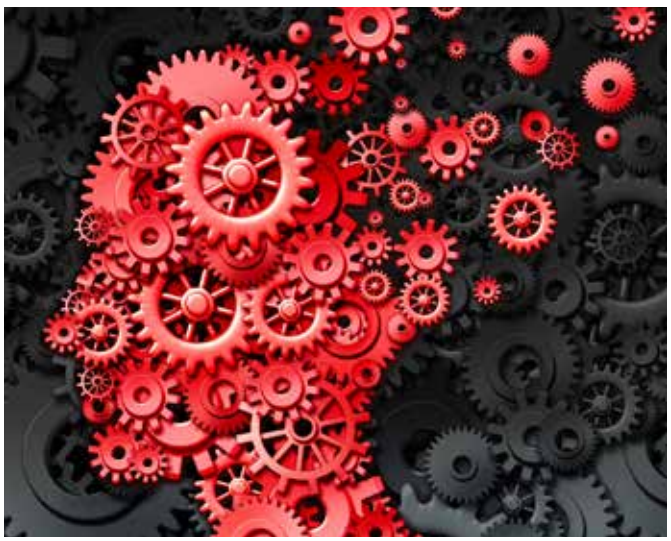
Reports highlight dementia as a major Australian illness



Dementia hospitalised almost 95,000 Australians in 2016-17, with $20 million spent on medications for the condition.

Two new reports from the Australian Institute of Health and Welfare (AIHW), show dementia to be a major cause of ill health and death in Australia, affecting up to 436,000 Australians in 2018 and causing more than 13,700 deaths in 2017.

The first report, *Hospital care for people with dementia 2016-17*, found there were 94,800 admissions to hospital of people with at least one diagnosis of dementia.

Ninety-two per cent of hospitalisations involved at least one overnight stay, with an average length of stay of 13 days.

Dementia was recorded as the principal diagnosis in twenty-two percent of hospitalisations. For the other 78 per cent of hospitalisations, dementia was recorded as an additional diagnosis.

Most patients hospitalised with dementia had an average of eight additional health conditions, commonly related to the urinary system (42 per cent) and type 2 diabetes (24 per cent).

Where dementia was an additional diagnosis, the most common principal diagnosis was related to injury (21 per cent), and more than one in three (36 per cent) of these were for a leg fracture.

The AIHW also released *Dispensing patterns for anti-dementia medications 2016-17*, which examines dispensing patterns for four anti-dementia medications and the associated costs to people and the Government.

"These four prescription medications were dispensed a total of 546,000 times in 2016-17, at a cost of $20 million," AIHW spokesman Richard Juckes said.

The full reports can be found at:

https://www.aihw.gov.au/reports/dementia/dispensing-patterns-for-anti-dementia-medications/contents/table-of-contents

and

https://www.aihw.gov.au/reports/dementia/hospital-care-for-people-with-dementia-2016-17/contents/table-of-contents

Responding to the research, Dementia Australia released two companion reports analysing the key issues highlighted by the AIHW.

Dementia Australia CEO Maree McCabe said the AIHW reports reinforce that more needs to be done to provide quality care for people living with dementia.

"With the number of people living with dementia expected to increase to an estimated 1.1 million by 2058, this data reinforces for us that we must act now to improve medication management and support for people living with dementia in hospital environments," Ms McCabe said.

Dementia Australia's paper *Medication use by people living with dementia* makes a number of recommendations including that anti-psychotics are used as a last resort and quality training in dementia care is provided for all staff working in hospitals.

Dementia Australia's paper Hospital care for people living with dementia includes recommendations that the physical environment of hospitals adheres to dementia-friendly design principles and that hospitals provide mandatory staff training in dementia.

Both reports can be accessed at: https://www.dementia.org.au/publications/reports

CHRIS JOHNSON

AIHW releases summary on hospital statistics

The Australian Institute of Health and Welfare has released its *Hospitals at a Glance 2017-18* report.

The statistics reveal there were 11.3 million hospitalisations in public and private hospitals combined in that 12-month period. Of all hospitalisations, 2.0 per cent involved a hospital-acquired complication. A total of $71 billion (excluding depreciation) was spent on public hospital services; and eight million patients presented to emergency departments.

"Hospitals are an important part of Australia's health landscape, providing services to many Australians each year. A summary measure of their significant role is the amount that is spent on them—an estimated $69 billion in 2016–17, about 4 per cent of Australia's gross domestic product, or $3,046 per person," the report states.

"Hospital spending has increased faster than inflation—up 2.8 per cent each year (adjusted for inflation), on average, between 2011–12 and 2016–17."

The AMA has repeatedly called for public hospitals to be better resourced and funded.

"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," AMA President Dr Tony Bartone said.

"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.

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

The AMA's *2019 AMA Public Hospital Report Card* can be found at:

https://ama.com.au/ama-public-hospital-report-card-2019

The AIHW's summary report can be found at https://www.aihw.gov.au/reports/hospitals/hospitals-at-aglance-2017-18 and presents an overview of statistics on access to hospital services, the quality of the services, and their funding and management arrangements.

CHRIS JOHNSON

Antimicrobial Stewardship

BY **DR PAUL BARTLEY**

The cover photograph on old, book-versions of the *Australian Therapeutic Guidelines-Antibiotic* is of a blood agar plate featuring colonies of Penicillium chrysogenum and Staphylococcus aureus – a modern facsimile of Fleming's original experiments demonstrating the antibacterial activity of penicillin. One of Fleming's subsequent insights was that S. aureus was capable of restricted growth in low concentrations of Penicillin and effectively predicted the potential for these emerging compounds to induce antibiotic resistance and therefore risk treatment failure.

Collectively, antibiotics are typically drugs with a broad therapeutic index (with notable exceptions) which, when prescribed in an evidence-based manner, are profoundly effective in reducing morbidity and mortality consequent to infection. However, throughout the 'golden' antibiotic era, all classes of micro-organisms, but especially bacteria, have demonstrated their ability to acquire resistance mechanisms to compounds which they were previously susceptible.

Notable examples include penicillin and methicillin resistance in S. aureus, extended-spectrum betalactamase (ESBL) production by E. coli, penicillin-resistant Neisseria meningitidis, extended drug resistant strains of Neisseria gonorrhoeae, ceftriaxone and ciprofloxacin-resistant strains of Salmonella Typhi, multidrug and extended drug-resistant strains of Mycobacterium tuberculosis and quinine-resistant Plasmodium falciparum.

The successful treatment of these leaves the patient and treating clinician with options limited to third-line, costly or more toxic drugs that very often can only be administered in a hospital or hospital-in-the-home intravenous program; and frequently an increased mortality risk. Currently, 700,000 deaths per year (worldwide) are directly attributable to multi-resistant organism infections, representing a major, emerging public health problem. Deaths from multiresistant organism infections are predicted to reach 10 million per annum by 2050. Additionally, a lack of antimicrobials could significantly restrict future capacity for many procedures including organ transplantation, cancer chemotherapy, major surgery and treatment of diabetic complications.

Some decades ago, 'dirty hospitals' took much of the obloquy for the selection and transmission of 'superbugs' as a consequence of antibiotic misuse, overuse and poor infection control practices. In response, there have been dramatic, evidence-based improvements in infection control, antibiotic management, antimicrobial stewardship and hospital regulation and administration that have been instrumental in improving patient safety and reducing the risk of selecting and transmitting multiresistant organisms and the separation of the prescribing of medicines from dispensing.

However, many of the multi-resistant pathogens listed above have been selected as a consequence of treatment in the community, whether or not the patient was treated in a Western or developing country. Antimicrobial resistance occurs where antimicrobials are prescribed. It is essential that antimicrobial susceptibility be preserved for our patients for as long as possible.

Antimicrobial stewardship has been part of the normal practice for infectious disease physicians and medical microbiologists for decades. It has evolved into a true multi-disciplinary process that includes pharmacists, nurses, hospital administrators and doctors from other disciplines; and is a mandated accreditation requirement for all hospitals by the ACSQHC. Nationally, antimicrobial stewardship also includes the veterinary and agricultural sectors. Within hospitals it dovetails in with infection control, vaccination strategies and hand hygiene programs to reduce the risk of patients acquiring infections, in addition to minimising the selection and transmission of multiresistant pathogens.

The stewardship process emphasises the importance of collecting appropriate cultures before commencing antibiotics therapy - not only the 'correct' antibiotic, but also the revision of treatment when culture results are available, the role of surgical drainage and removal of redundant devices, the use of an antibiotic with an appropriate spectrum for the appropriate duration. Audits according to nationally standardised criteria.

Antimicrobial stewardship opportunities exist in all disciplines of medicine and is a process that all Doctors, to varying extents

Antimicrobial Stewardship ...continued from p12

need to support and participate in, commensurate with their practice. Such examples include the appropriate timing of pre-operative antibiotic prophylaxis, using narrower-spectrum agents for non-severe lower-respiratory tract infection, avoiding antibiotic use for viral URTI, delayed prescribing strategies for patients with early or protean symptoms, and switching to narrower spectrum agents when cultures demonstrate susceptibility.

Many clinicians may find this daunting, and for some could represent significant practice changes – but this needs to be balanced with the knowledge of the potential harms of antibiotics, the harm from multi-resistant organism infection (including increased mortality risk for our patients) and the benefits accrued from using narrower spectrum agents. There are numerous CPD programs to support clinicians in this process.

The responsibility of prescribing is conferred to medical graduates after demonstrating sufficient aptitude in the diagnosis and management of the whole patient with any particular disease. Given the history of antimicrobials and the emerging threat of antimicrobial resistance, it is difficult to therefore understand the approach taken by the Queensland Minister for Health, the Honorable Stephen Miles MLA, to allow the prescriptions of trimethoprim by pharmacists – whose primary qualifications do not include training in the diagnosis or management of disease – directly to patients for the treatment of urogenital symptoms against the express advice to the contrary from Australian Medical Association Queensland, the Australasian Society for Infectious Diseases, the Australian College of Rural and Regional Medicine and the Royal Australasian College of General Practitioners. In addition to diminishing the impact of many Queensland Health initiatives to tackle antimicrobial resistance; and dismissive of Medical training and CPD requirements, the ersatz rationale for this decision risks harming our patients and the decision needs to be reversed.

Dr Paul Bartley, BMedSc, MBBS, FRACP, FRCPA, PhD, Infectious Diseases Specialist, Wesley Hospital, Brisbane; Co-Chair of the Uniting Care Health Antimicrobial Stewardship Committee; and AMA Queensland Infectious Diseases Specialist spokesman.

INFORMATION FOR MEMBERS

AMA Fees List – 1 September 2019 Changes

The 1 September 2019 changes to the AMA Fees List are now available from Fees List Online: https://feeslist.ama.com.au/

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

As well as the changes within the main database of FeesList Online, there is a Summary of Changes for you to review what changes have been made.

To access the AMA Feeslist Online, members require a Federal username and password for ama.com.au.

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 the FeesList website 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

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

President gives evidence on Medevac

AMA President Dr Tony Bartone has told a Senate committee reviewing the Medevac laws that the Independent Health Advisory Panel (IHAP) assessing the health of asylum seekers is working well.

The Government is seeking to repeal Medevac, which currently gives doctors the say in whether refugees on Manus and Nauru should be brought to mainland Australia for medical treatment.

A repeal bill passed in the House of Representatives and is now under review in the Senate before it is voted on there later this year.

Then Committee heard evidence from a number of stakeholders.

In his evidence, Dr Bartone said it remained vital that doctors have independent access to asylum seekers.

"Asylum seekers and refugees experience particular risks from a range of health conditions and psychological disorders," he told the inquiry.

"Post-traumatic stress disorder, anxiety, depression, and the physical effects of persecution and torture are common among asylum seekers and refugees, along with poorer physical health."

Dr Bartone described the transfer process of sick refugees prior to the Medevac laws as "tortuous" and invariably involving long delays.

He said the review process under the Medevac laws was functioning well, albeit not perfect. Under the current law, IHAP members are not paid for their service.

"From all reports, I believe that the IHAP process is working well in that applications are being brought to it in an appropriate manner

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

and an appropriate timeframe," Dr Bartone told the hearing.

"All applications, I believe, that have been presented to the committee have been assessed and appropriately acted upon in due course.

"From our point of view, and from the information that we have … it is working as intended. All the doctors on IHAP have been performing under exceptionally difficult circumstances, have been executing their tasks in the most professional, the most ethical, and the most capable of manners. And I have nothing but respect for all the members of the IHAP committee."

When asked what he considered a fair level of remuneration for doctors serving on IHAP, Dr Bartone replied that "zero" was not a fair level.

Professor Kerryn Phelps, a former AMA President and the former Federal Member for Wentworth, also gave evidence before the committee in a personal capacity. Professor Phelps spearheaded much of the campaign that resulted in the Medevac legislation passing in February.

She told the hearing that the Government's repeal bill should be opposed in its entirety. Professor Phelps even took issue with the name of the bill – the Migration Amendment (Repairing Medical Transfers) Bill 2019.

"What needs to be repaired is Australia's treatment of people seeking asylum," she said.

"Not the bill that provides for humane and timely medical transfer of seriously ill people on Manus Island and Nauru."

CHRIS JOHNSON

Research

WITH CHRIS JOHNSON

New measuring method gives Aussie men top life expectancy

Australian National University (ANU) research has found Australian men to be living longer than any other group of males in the world.

Using a new way of measuring life expectancy, which accounts for historical mortality conditions today's older generations lived through, the study found that Australian men live, on average, to 74.1 years of age.

The same method also shows Australian women to be ranked high, second only to Swiss women – 78.8 and 79.0, respectively.

The study used data from 15 countries across the globe with high life expectancies.

The ANU's Dr Collin Payne co-led the study.

"Popular belief has it that Japan and Nordic countries are doing really well in terms of health, wellbeing and longevity. But Australia is right there," Dr Payne said.

"The results have a lot to do with long-term stability and the fact Australia's had a high standard of living for a really long time. Simple things like having enough to eat, and not seeing a lot of major conflict, play a part."

The study grouped people by year of birth, separating early deaths from late deaths, to come up with the age at which someone can be considered an above-average survivor.

"Most measures of life expectancy are just based on mortality rates at a given time," Dr Payne said.

"It's basically saying if you took a hypothetical group of people and put them through the mortality rates that a country experienced in 2018, for example, they would live to an average age of 80.

"But that doesn't tell you anything about the life courses of people, as they've lived through to old age. Our measure takes the life course into account, including mortality rates from 50, 60, or 70 years ago. What matters is we're comparing a group of people who were born in the same year, and so have experienced similar conditions throughout their life."

The method allows researchers to clearly see whether someone is reaching their cohort's life expectancy.

And there are a number of factors that might have contributed to Australia jumping ahead in these new rankings.

Any Australian man who is above 74 years of age has outlived half of his cohort, Dr Payne said, and the method provides that with 100 per certainty.

"He's an above-average survivor compared to his peers born in the same year," he said.

"On the other hand, any man who's died before age 74 is not living up to their cohort's life expectancy.

"Mortality was really high in Japan in the 30s, 40s and 50s. In Australia, mortality was really low during that time. French males, for example, drop out because a lot of them died during World War Two, some from direct conflict, others from childhood conditions."

Researchers are now hoping to get enough data to look at how rankings have changed over the last 30 to 40 years.

Countries with the highest life expectancy based on new Lagged Cohort Life Expectancy (LCLE) method:

Men	Women
Australia (74.1)	Switzerland (79.0)
Sweden (74.0)	Australia (78.8)
Switzerland (73.7)	Norway (78.6)
Norway (73.1)	Sweden (78.4)
Netherlands (72.6)	Netherlands (78.2)

Mental health crises in the bush

The dearth of dedicated clinical mental health support and intervention services in remote Australia dissuades many people from seeking help until they are in crisis, according to research from the Royal Flying Doctor Service published by the *Medical Journal of Australia.*

Research

According to the research, there is little difference in prevalence of mental illness between city and bush, yet poor service access, distance, cost and continued reluctance to seek help, all contribute to higher mental illness acuity and suicide rates.

A total of 2,257 patients were retrieved by the RFDS between July 1, 2014 and June 30, 2017 for treatment of mental or behavioural disorders. Of these, 62 per cent were males (1,394) and 38 per cent were females (863).

Sixty per cent of patients were under 40 years of age, 35 per cent identified as Indigenous Australians. Most retrieval sites were rural and remote communities with low levels of support for mental disorders.

The most frequent mental and behavioural disorders were schizophrenia (227 retrievals, 16.5 per cent), bipolar affective disorder (185 - 13.5 per cent), and depressive episodes (153 - 11.2 per cent).

Psychoactive substance misuse triggered 194 retrievals (14.2 per cent), including misuse of multiple drugs (85 - 6.2 per cent), alcohol (61 - 4.5 per cent), and cannabinoids (25 - 1.8 per cent).

The mean age of patients retrieved for treatment of substance misuse was 29.6 years, which was lower than for retrieved patients overall (37.0 years). Thirty-eight of 194 patients retrieved after psychoactive substance misuse were under 19 years of age.

Dr Fergus Gardiner, Director of Research and Policy with the RFDS, led the study and said the increasing number of retrievals for diagnoses of bipolar affective disorder in children under 14 years was unexpectedly high.

“This may reflect confusion of the symptoms of bipolar affective disorder with the acute behavioural manifestations of attention deficit/hyperactivity disorder, obsessive–compulsive disorder, conduct disorder, learning disorders, pervasive developmental disorders, and unipolar depressive disorders,” Dr Gardiner and colleagues wrote.

“Alternatively, it may reflect the context-specific nature of mental health-related retrievals of children from remote locations: a diagnosis of bipolar affective disorder may be perceived as more acceptable for initiating aeromedical retrieval.

“The high number of bipolar affective disorder diagnoses among retrieved children nevertheless warrants further investigation.”

The study concludes that due to the absence of access to local dedicated mental health support and intervention services, many patients seek clinical assistance only when in crisis. The availability of RFDS and non-RFDS mental health clinical support is lower in most of the retrieval communities than in major cities.

Research

Lower back pain not caused by sitting

A mega-study into the causes of back pain has found no association between prolonged sitting and lower back pain.

The Deakin University findings are being described by the institution as good news for those with desk jobs.

An umbrella review was led by Deakin's Institute for Physical Activity and Nutrition (IPAN), and sifted through 41 different systematic reviews to better understand what movements or tasks are risk factors for back pain.

The findings are the result of three decades of data collection from more than one million subjects, giving the most accurate picture yet of the relationship between certain activities and back pain.

IPAN Associate Professor of Exercise and Musculoskeletal Health, Daniel Belavy, said when looking at the studies in combination, the strongest evidence his team found was actually the absence of a relationship, with no association between prolonged or occupational sitting and lower back pain.

"Despite a growing body of evidence linking sitting to other negative health effects, when it comes to back pain, sitting does not appear to be a risk factor," Associate Professor Belavy said.

"So, while you may get muscle tightness when you sit for a long time, sitting itself doesn't actually damage the spinal structures directly."

But it's not good news for all workers. Professor Belavy said heavy physical work and lifting were associated with back pain in his review, although it is still not clear that they are actually likely to cause it.

"Both of those things might sound the same, but it's one thing to find an association and quite another thing to prove causality," he said.

"Studies on causality are few and far between because they are harder to do. So it's important we keep working to better understand the mechanisms behind lower back pain.

"For those under 50, back pain causes the greatest loss of productivity of all diseases in Australia, and 16 per cent of Australians will develop persistent back pain at some point in their life."

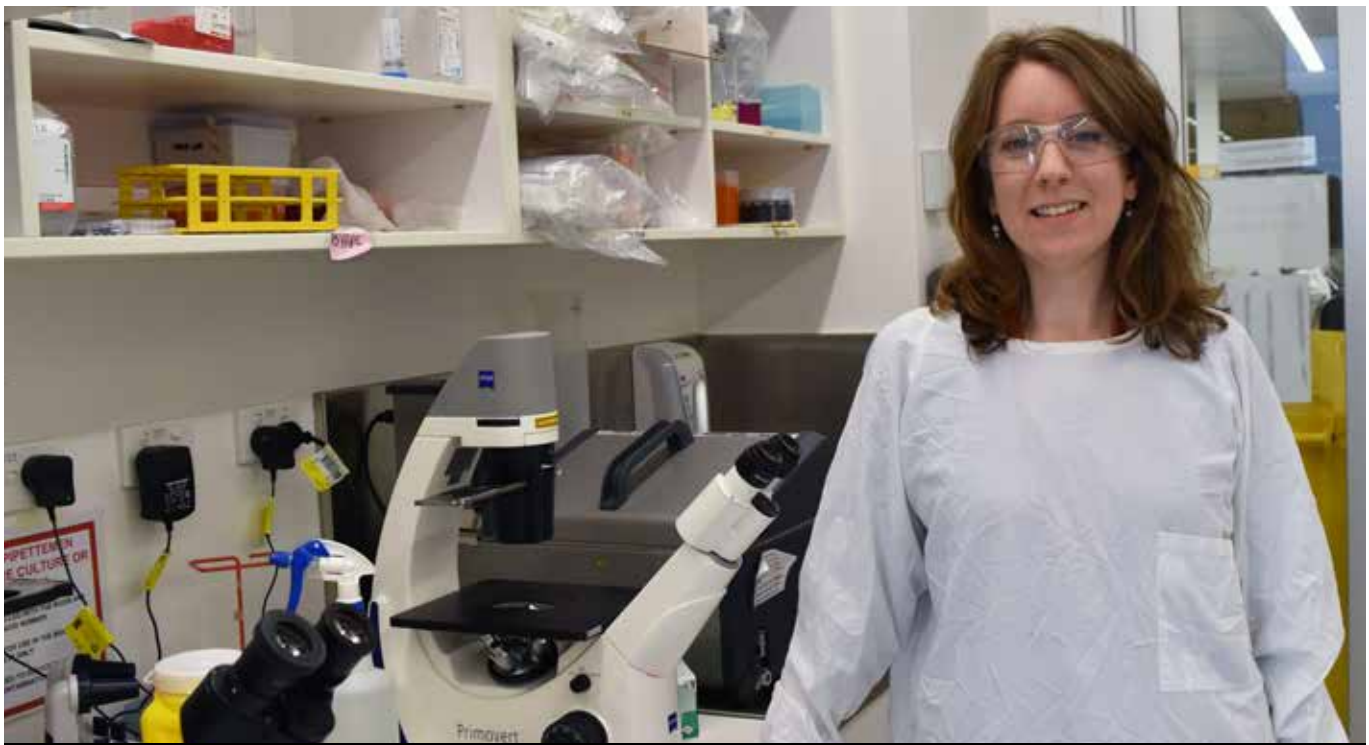
The study has been published in the *Journal of Biomechanics*.

New TB vaccine being tested

Australian medical researchers from the Centenary Institute and the University of Sydney have successfully developed and tested a new type of vaccine targeting tuberculosis (TB), the world's top infectious disease killer.

Reported in the *Journal of Medicinal Chemistry*, the early-stage vaccine was shown to provide substantial protection against TB in a pre-clinical laboratory setting. The research program targeting the deadly disease has currently taken more than five years of effort to implement.

Research



Dr Anneliese Ashhurst

TB is caused by a bacterium that infects the lungs after it is inhaled, and it is highly contagious. The disease results in about 1.6 million deaths per year globally. An estimated two billion individuals are carrying TB and up to 10 per cent of these develop the disease in their lifetime. More than 50 per cent of TB cases occur in the Asia Pacific region.

Dr Anneliese Ashhurst, co-lead author of the study, created, with a team of scientists, the advanced synthetic TB vaccine. They have now demonstrated its effectiveness using mouse models.

"Two peptides (small proteins) which are normally found in tuberculosis bacteria were synthesised and then bound extremely tightly to an adjuvant (a stimulant) that was able to kick-start the immune response in the lungs," Dr Ashhurst said.

"We were then able to show that when this vaccine was inhaled into the lungs, it stimulated the type of T cells known to protect against TB. Importantly, we then demonstrated that this type of vaccine could successfully protect against experimental airborne TB infection."

There currently exists only one lone vaccine for TB (known as BCG) and this is only effective in reducing the risk of disease for infants.

The Centenary Institute is an independent medical research institute, closely affiliated to the University of Sydney and the Royal Prince Alfred Hospital.

Rhesus D two-dose regimen better than single

The current Australian recommendation of two-dose antenatal anti-D prophylaxis has been shown to provide greater protection than the single dose recommended by some other countries, but compliance with treatment could be improved. That is according to new researched published by the *Medical Journal of Australia.*

Research

Rhesus D (Rh(D)) isoimmunisation occurs when an Rh(D)-negative mother forms Rh(D)-immunoglobulin antibodies (anti-D) in response to exposure to Rh(D)-positive fetal red blood cells; these antibodies can cross the placenta during a subsequent pregnancy with an Rh(D)-positive fetus and initiate immune-mediated haemolysis (rupturing of red blood cells).

Routine antenatal anti-D prophylaxis (RAADP) reduces the risk of Rh(D) sensitisation of pregnant women, but until now it has been unclear whether the two-dose regimen recommended in Australia was superior to the single-dose regimen.

Dr Scott White, a consultant obstetrician at the King Edward Memorial Hospital in Perth, and a senior lecturer at the University of WA, led colleagues in administering either one 1500 IU anti-D dose at 28 weeks of pregnancy (single dose regimen); or two doses of 625 IU each at 28 and 34 weeks of pregnancy (two-dose regimen) to 277 women who attended King Edward for antenatal care and were at least 18 years of age, less than 30 weeks pregnant and yet to receive RAADP, Rh(D)-negative (negative antibody screen), and intending to deliver their baby at the hospital.

They found that circulating anti-D was detectable at delivery in a greater proportion of women in the two-dose group (111 of 129 – 86 per cent) than in the single dose group (70 of 125 – 56 per cent). Compliance (receiving treatment on schedule) was similar in the single (86 of 138 – 61 per cent) and two-dose groups (70 of 139 – 50 per cent).

"Circulating anti-D levels were too low for detection at delivery in significantly more women who received RAADP as a single dose rather than in women who received the standard two doses," Dr White and colleagues said.

"Undetectably low levels leave women vulnerable to sensitisation in the event of an asymptomatic feto-maternal haemorrhage of 0.6 mL, which occur in one per cent of pregnant women during their third trimester. Although the two-dose RAADP regimen, standard in Australia, thus seems superior to a single dose approach, the absolute risk of sensitisation is likely to be small.

"The number needed to treat with two-dose RAADP to prevent one case of undetectable anti-D at birth is 3.1 based on the observed absolute risk reduction of 32 per cent. However, only one per cent of women with undetectable anti-D levels at delivery are likely to be sensitised, so that one case of sensitisation could be prevented for about every 300 women by using two-dose rather than single dose RAADP.

"Compliance with the allocated RAADP regimen was relatively low in both groups ... indicating that systematic improvements are required to ensure that RAADP is administered as recommended.

"Our trial provides indirect evidence for greater protection against Rh(D) sensitisation by the RAADP regimen recommended by Australian guidelines than by the single dose regimen used in some other countries. Systematic improvements that facilitate improved compliance with the current recommendations are needed to minimise the risk of isoimmunisation in Rh(D)-negative women."

World News

WITH CHRIS JOHNSON

Microplastics and their potential to harm health

The World Health Organisation has called for a further assessment of microplastics in the environment and their potential impacts on human health, following the release of an analysis of current research related to microplastics in drinking-water. The Organisation also calls for a reduction in plastic pollution to benefit the environment and reduce human exposure.

"We urgently need to know more about the health impact of microplastics because they are everywhere – including in our drinking-water," said Dr Maria Neira, WHO's Director of Department of Public Health, Environment and Social Determinants of Health.

"Based on the limited information we have, microplastics in drinking water don't appear to pose a health risk at current levels. But we need to find out more. We also need to stop the rise in plastic pollution worldwide."

According to the analysis, which summarises the latest knowledge on microplastics in drinking-water, microplastics larger than 150 micrometres are not likely to be absorbed in the human body and uptake of smaller particles is expected to be limited. Absorption and distribution of very small microplastic particles including in the nano size range may, however, be higher, although the data is extremely limited.

Further research is needed to obtain a more accurate assessment of exposure to microplastics and their potential impacts on human health. These include developing standard methods for measuring microplastic particles in water; more studies on the sources and occurrence of microplastics in fresh water; and the efficacy of different treatment processes.

WHO recommends drinking-water suppliers and regulators prioritise removing microbial pathogens and chemicals that are known risks to human health, such as those causing deadly diarrhoeal diseases. This has a double advantage: wastewater and drinking-water treatment systems that treat faecal content and chemicals are also effective in removing microplastics.

Wastewater treatment can remove more than 90 per cent of microplastics from wastewater, with the highest removal coming from tertiary treatment such as filtration. Conventional drinking-water treatment can remove particles smaller than a micrometre. A significant proportion of the global population currently does not benefit from adequate water and sewage treatment. By addressing the problem of human exposure to faecally contaminated water, communities can simultaneously address the concern related to microplastics.

World News

Burundi moves to protect front-line workers from Ebola

African nation Burundi has started its Ebola vaccination campaign for health workers and front-line staff working priority areas where the risk of transmission is significant.

The country's Ministry of Public Health and AIDS Control started the campaign at the Gatumba entry point at the Border with the Democratic Republic of Congo (DRC).

Burundi has received doses of the Ebola vaccine (rVSV-ZEBOV) to provide protection against the Zairian strain of the virus, which is currently affecting the DRC. Although this vaccine is not yet approved and its commercial use is not yet authorised, it has been shown to be effective and safe during Ebola outbreaks in West Africa. Further scientific research is required before the vaccine can be licensed.

The vaccine is used for humanitarian purposes to protect people most at risk of an Ebola outbreak. These are health workers working at points of entry into the country, as well as other people potentially exposed to the Ebola virus disease, such as laboratory workers, surveillance teams and people responsible for carrying out dignified and secure burials.

The campaign is part of Burundi's preparation for a possible case of Ebola. The campaign will be implemented under leadership of the Ministry of Public Health and AIDS Control, with the support of WHO, and with financial support provided by GAVI, the Vaccine Alliance.

"The vaccination of health and front-line staff is a significant step forward in preparing for the response to this disease," said Dr Kazadi Mulombo, WHO Representative in Burundi.

"The vaccine proved highly protective against Ebola in a trial conducted in Guinea in 2015. Pending consideration by the relevant regulatory authorities, the WHO Strategic Advisory Group of Experts on Immunisation recommended that the rVSV-ZEBOV vaccine be used as part of a protocol on expanded access and compassionate use during Ebola outbreaks related to the Zaire strain, such as the current one in the DRC. In Burundi, we will use it for prevention purposes."

No cases of Ebola have been reported in Burundi, but preparation remains crucial.

American Medical Association takes stand against discrimination

The American Medical Association has spoken out against the Trump administration's proposal to remove anti-discrimination protections related to sexual orientation, gender identity, and the termination of pregnancy across a wide variety of health care programs and insurance plans.

The Association noted that the proposal went against the nondiscrimination provisions included in the Affordable Care Act by drastically limiting coverage protections despite decades of case law recognising these protections.

"This proposal marks the rare occasion in which a federal agency seeks to remove civil rights protections. It legitimises unequal treatment of patients by not only providers, healthcare organizations, and insurers, but also by the Government itself—and it will harm patients. Such policy should not be permitted by the U.S. Government, let alone proposed by it," the Association wrote in a submission letter to a Government committee.

It said undoing the protections of the current rule will cause confusion about what the law requires and who is protected by it and, in doing so, will limit access to critically needed care and services for millions of individuals.

The proposed rule disproportionately harms people seeking reproductive health care (including abortion), LGBTQ individuals, individuals with LEP (including immigrants), those living with disabilities, and people of colour, it said.

World News

WHO commitment to Pacific and climate action

WHO Director-General Dr Tedros Adhanom Ghebreyesus has completed a two-week mission to Pacific Island countries and reiterated WHO's unflagging commitment to supporting their efforts to advance health and wellbeing.

At the opening session of the Pacific Health Ministers' Meeting, Dr Tedros told Pacific Island Leaders that: "WHO is committed to you and the people of the Pacific."

He noted the importance of ensuring that the voices of the Pacific are heard on the global stage, including at the UN General Assembly high-level meetings on universal health coverage and the Climate Action Summit.

Pressing issues included:

- strengthening primary health care as key to advancing universal health coverage, including through robust monitoring and evaluation;
- ways to reinforce national systems and institutions to further develop the health workforce;
- developing multisectoral approaches and scaling up services to prevent and treat noncommunicable diseases (the leading cause of death in the region);
- improving health security, for example through steps to improve preparedness for outbreaks of diseases such as dengue; and
- tackling the health impacts of climate change – and the important role that Pacific Island countries have to play in highlighting the negative effects of climate change and helping to identify solutions.

In 2017, WHO established a special initiative on climate change and health in small island developing states, launching it in cooperation with Frank Bainimarama, Prime Minister of Fiji, who was president of COP23 in Bonn. Following consultations with Indian Ocean, Caribbean and Pacific island countries, WHO developed an action plan which was endorsed at the World Health Assembly in May 2019. WHO is now supporting countries in implementing that plan.

Speaking at the Climate Change Summit in Tuvalu, Dr Tedros told delegates that WHO had been mandated to develop two health commitments for the UN Climate Action Summit. These were to save lives by cutting carbon emissions and cleaning our air; and boosting investments in climate action, public health and sustainable development.

World News

World must unite to ban tobacco sponsorship

Governments around the world must comprehensively enforce bans on tobacco advertising, promotion and sponsorship at international expos and conferences, in order to ensure their events and programs are tobacco free and that their activities and participants are not sponsored by tobacco companies.

The World Health Organisation has renewed this call, as part of its Framework Convention on Tobacco Control. The WHO insists the world must unite to halt the tobacco industry's aggressive marketing of its products, that cause addiction, suffering and millions of deaths each year.

This renewed call comes in light of reports of tobacco companies aiming to establish new partnerships with governments to sponsor events or pavilions in world expos, in a country that has already ratified the WHO Framework Convention on Tobacco Control (FCTC).

Philip Morris International (PMI) recently announced a partnership with the Government of Switzerland to sponsor the Swiss pavilion in the Dubai World Expo 2020. The Government of Switzerland has reconsidered this partnership, and chosen not to accept the financial support of PMI. WHO welcomes the decision made by the Government of Switzerland and takes this opportunity to encourage the Government to ratify the WHO Framework Convention on Tobacco Control (FCTC), as Switzerland is among a handful of countries that are yet to do so.

The WHO Framework Convention on Tobacco Control includes in Article 5.3 a commitment to protect public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry. This commitment is reflected in the Memorandum of Understanding of 2011 between WHO and the Bureau International des Expositions (BIE), which 'bans' sponsorship of expos by tobacco companies or their agents or affiliates.

Featuring a world-leading producer of tobacco products and cigarettes — the only product that is known to kill half of its consumers, goes against the theme of Dubai's Expo 2020 *'Connecting Minds, Creating the Future'*. Governments must proactively aspire to reduce the number of people starting and continuing smoking, to promote health and preserve future generations.

In accordance with Article 8 of the WHO Framework Convention on Tobacco Control, WHO also urges all organisers of international expos and conferences to adopt complete tobacco-free policies providing for protection from exposure from tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places. Any designated smoking area must be outdoor and designed to discourage smoking and to protect people from tobacco smoke exposures. In addition, governments should:

- Ban sales of tobacco or tobacco-related products at expos;
- Ban sponsorship of expos by tobacco companies or their agents or affiliates; and
- Ban advertising and promotion of tobacco products, tobacco company brands, and the use of tobacco at expos.

World News

BMA responds to low MMR vax rate

The British Medical Association has responded to Public Health England's estimates that one in seven children aged five have yet to be fully immunised against measles, mumps and rubella.

This comes as the cases of measles rise across Britain in the face of ill-informed ant-vaccination campaigns.

BMA Board of Science Chair, Professor Dame Parveen Kumar said: "Doctors are very concerned that the number of young children who are up to date with vaccinations seems to be falling. Measles can be a very serious illness and whilst diphtheria and whooping cough are thankfully relatively rare, they remain a risk to children who are not vaccinated.

"The BMA has always maintained that the Government and NHS England must take practical steps to make people far more aware of their local immunisation services and ensure they have proper access to them. However, health leaders have been slow to act – proven by these figures from Public Health England.

"The Prime Minister's announcement on measures to improve vaccination rates is long overdue and though welcome, more must be done.

"Frontline medical staff must be given the resources to provide a successful and comprehensive vaccination program – to protect children in all parts of the population. In addition, support must be readily available to help parents and carers better understand the importance of vaccinating their children and make an informed decision."

INFORMATION FOR MEMBERS

Voluntary assisted dying laws begin

On November 29, 2017, the Victorian Parliament passed the *Voluntary Assisted Dying Act* 2017.

From June 19, 2019, Victorians at the end of life who are suffering and who meet strict eligibility criteria will be able to request access to voluntary assisted dying.

The law allows for an 18-month implementation period to give health services time to plan and prepare for voluntary assisted dying.

Health Victoria provides an extensive range of information for 'consumer and community information' as well as 'health practitioners and services information'. These are available at: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioners.

These resources include explicit information for doctors who wish to participate in VAD as well as those who do not wish to participate including those with a conscientious objection to VAD. Guidance is also provided for doctors and other healthcare practitioners on how to respond to a patient's request for information on VAD (A health practitioner who is providing health or professional care services to a patient cannot initiate a discussion about voluntary assisted dying or suggest voluntary assisted dying to the patient. They can, however, respond to a patient's request for information).

Through the AMA Victoria Peer Support or VDHP, AMA Victoria will continue to support all Victorian members and listen to their views during the VAD process. Please refer to the AMA Victoria website at https://amavic.com.au/policy-and-advocacy/voluntary-assisted-dying

Background information to VAD services in Victoria

How the service works (from Health Victoria, Voluntary Assisted Dying, Overview)

- Voluntary assisted dying is only for people who are suffering from an incurable, advanced and progressive disease, illness or medical condition, who are experiencing intolerable suffering. The condition must be assessed by two medical practitioners and be expected to cause death within six months. The doctors will make sure the person is making a fully informed decision and is aware of the available palliative care options.
- There is an exception for a person suffering from a neurodegenerative condition, where instead the condition must be expected to cause death within 12 months.
- Voluntary assisted dying will only be available to Victorians who are over the age of 18 who have lived in Victoria for at least 12 months, and who have decision-making capacity. To be eligible for voluntary assisted dying they must be experiencing suffering that cannot be relieved in a manner the person considers tolerable.
- Mental illness or disability alone are not grounds for access to voluntary assisted dying, but people who meet all other criteria, and who have a disability or mental illness, will not be denied access to voluntary assisted dying.
- Only the person wanting to access voluntary assisted dying may initiate discussions with health practitioners about voluntary assisted dying. A family member or carer can't request voluntary assisted dying on somebody else's behalf.
- On receiving a final request, the doctor will apply for a permit to prescribe a medication that the person may use to end their life at a time of their choosing. The person must administer the medication themselves, unless they are physically unable to do so, in which case their doctor may assist.
- No health practitioner or healthcare provider will be obliged to participate in voluntary assisted dying.

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