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End the decay

Indigenous Health Report Card, p3

INSIDE

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AMA LEADERSHIP TEAM

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Dr Tony Bartone

Vice President
Dr Chris Zappala

In this issue

Health system must better address Indigenous dental health

With Dr Bartone are Shadow Assistant Minister for Indigenous Health Warren Snowdon, Shannon Daly from the Danila Dilba Health Service, and Northern Territory Health Minister Natasha Fyles.

Indigenous Australians suffer an unacceptable rate of dental disease and tooth loss, and should receive more Government attention to address the problem.

The AMA has released its *Indigenous Health Report Card 2019* and says the nation's health system is failing Indigenous communities.

To seriously address the situation, more communities must have access to fluoridated water, funding for dental services must be boosted in remote areas, more Indigenous dentists are needed, oral health promotion must be enhanced, and a sugar tax on sweet drinks should be introduced.

In Darwin to release the Report Card, AMA President Dr Tony Bartone said it was unacceptable that a significant proportion of the Aboriginal and Torres Strait Islander population lives without access to affordable, culturally appropriate dental care.

"Good oral health is fundamental to overall health and wellbeing. It allows people to eat, speak, and socialise without pain, discomfort, or embarrassment," Dr Bartone said.

"Aboriginal and Torres Strait Islander pre-school and primary school-aged children are more likely to be hospitalised for dental problems, and are less likely to receive preventive care, and adults and children from Indigenous backgrounds have much higher levels of untreated tooth decay.

"Poor oral health complicates and contributes to other illnesses, especially rheumatic heart disease and diabetes – illnesses that afflict Aboriginal and Torres Strait Islander Australians at a far greater rate than their non-Indigenous peers."

Indigenous Australians, adults and children, have dental disease at two or three times the rate of their non-Indigenous counterparts in urban, rural, and remote communities, and are five times more likely to have missing teeth, the Report Card shows.

And there are fewer than 100 Aboriginal or Torres Strait Islander dental practitioners in Australia.

Dr Bartone said Australians living in rural and remote areas need good-quality, affordable dental care, yet governments see oral health services for Aboriginal and Torres Strait Islander peoples as discretionary and short-term. Funding is piecemeal and arbitrary.

"Availability of dental services should be based on need. Funding should be transparent and every opportunity taken to build the community-controlled health sector with direct funding of vital prevention and dental treatment programs for the communities they serve," he said.

"Water fluoridation, reducing sugar consumption, oral health promotion, and fluoride varnish programs from the eruption of the first tooth all help to prevent tooth decay.

"In 2017, only 98 Aboriginal and Torres Strait Islander people were registered as dental practitioners. We know that Indigenous people have better health outcomes when they receive culturally safe health care in a service where staff understand and respect them."

Dr Bartone used the Report Card launch to call on all levels of Government to treble their investment in the Puggy Hunter Memorial Scholarship Scheme, and to set a goal of 780 Indigenous dental practitioners by 2040 to promote employment parity in the dental workforce.

"We urge all political leaders, at all levels of Government, to take note of this Report Card, and be motivated to work in partnership with Aboriginal peak bodies to find effective solutions and implement the recommendations," he said.

Key recommendations from the Report Card include: Governments committing to a minimum standard of 90 per cent population access to fluoridated water; a strategic approach and additional investment to increase Aboriginal and Torres Strait Islander participation in the dental practitioner workforce; Federal Government investment in oral health promotion being reinstated and evidence-based initiatives implemented; and the Federal Government introducing a tax on sugar-sweetened beverages.

The AMA also calls for better availability of comprehensive oral health data for Aboriginal and Torres Strait Islanders, to enable effective monitoring and performance measurement.

And service models must be developed and implemented in collaboration with Aboriginal and Torres Strait Islander people, with funding arrangements reflecting the varying costs of providing services in regional and remote areas.

CHRIS JOHNSON AND MARIA HAWTHORNE

The AMA Indigenous Health Report Card 2019 is available at: https://ama.com.au/article/2019-ama-report-card-indigenous-health-no-more-decay-addressing-oral-health-needs-aboriginal

The Government has had long enough

BY AMA PRESIDENT DR TONY BARTONE

> "The Coalition was returned and yet, just over six months since the Federal election, there is still to be any hint of an overarching vision put forward to the community and to our patients about a way forward with health reform."

Is this Government up to the challenge of meaningful health reform? I must say I am beginning to severely doubt it.

Why? During the election campaign in May 2019, the AMA put out its popular election scorecard. It drew significant attention from the media, and some uncomfortable comment from both sides as the election day beckoned. The media commentary focused on our headline that neither party had articulated a clear vision for our health system during the campaign.

The Coalition was returned and yet, just over six months since the Federal election, there is still to be any hint of an overarching vision put forward to the community and to our patients about a way forward with health reform.

Don't get me wrong. The Minister is trying.

He has announced three taskforces and three separate 10-year plans/visions for Primary Care, Preventative Health, and Mental Health. As AMA President and a GP, I am the only person common to all three taskforces.

This is an immensely opportune situation to ensure that a vision across all three areas speaks to the necessary issues of funding, coordination, and collaboration required across these three domains – and indeed the rest of the heath system.

But this is only seriously exciting if there is genuine commitment to appropriately fund the various plans with new investment. And this can be only if the investment is not at the expense of other parts of the health sector. Otherwise it cannot and simply will not work.

In fact, we all know words are cheap. They are very cheap especially if they are not accompanied by funding commitments to ensure actions and outcomes.

We really need to ask ourselves some very poignant and pressing questions.

How long before the penny drops in Government and the wider community that 10 per cent of GDP is never going to fund the current demand driven activity in our health system?

How long before we accept that we need to change the model of health care from a disease driven activity model to a proactive preventative coordinated and integrated one?

How long must we fumble along without an overarching vision and keep trying to tinker with different parts of the health service, hoping to eventually cobble a complete puzzle?

How long before we understand that without patient-centred primary care, which is properly resourced with infrastructure and coordinated integration, that we will keep seeing worsening clinical outcomes for our patients and the population as a whole?

If it sounds like I am frustrated, I am. In fact, I am downright disappointed that we are still having the same conversations that we have had for many years now. Clearly, we have a limited tolerance to this kind of activity. Our patience is being severely tested.

Perhaps it has gone even too far now. We are being carefully managed and every attempt is being made to water down, neutralise, and even distract from the main game.

We are being politely engaged and listened to, but then essentially dismissed, deferred, delayed, obfuscated, and buried with multiple – yes, multiple indeed – stakeholder forums, round tables, requests for information, or submissions. So many as to potentially distract, bury, and deviate from overall targeted and effective advocacy, and create inefficiencies or distractions in our responses and input – and try to weary us down strategically.

We are talking about frenetic activity. So frenetic that one hand does not know what the other hand is doing. Various parts of the

Department of Health (DOH) not talking to one another. And all along, this slapstick approach is occurring while the Government is trying to come out with solutions to very difficult issues. Issues such as the dwindling membership of PHI, especially among the younger members of the community.

My message to the Minister is to get real.

> "Is it time to call out the Government and, in particular, the Minister for not really being across his portfolio in a future-proofing way …"

My message to the DOH is get your house in order and realistically program the consultation. There is no point having consultation forums if they are at short notice with poor visibility and time frames – combined with an inability to effectively brief and prepare attendees, let alone the last minute voluminous papers dumped on secretariat and the representatives at 'T minus 5' minutes – and then wonder why invariably no one is appropriately across the brief or can even attend.

Then, to add fuel to the fire, the Department or Minister brazenly reports back that they widely consulted with industry and the health sector.

The question clearly is what next? What to do if the Government continues to create such administrative barriers and obstacles to consultation with the profession?

Is it time to call out the Government and, in particular, the Minister for not really being across his portfolio in a future-proofing way, but rather being still very much focused on cost containment?

I intend to put further pressure on the Minister and the Government. We need to be very clear about what is needed to improve our health system.

The AMA Federal Council has agreed to take up this challenge. A lot of work has been done producing some excellent reports and advocacy, such as the reports cards on PHI and public hospitals and submissions on aged care to name just a few.

We will be distilling it further and joining the dots to clearly articulate the lack of an overarching vision from the Government, and offer a plausible coherent and coordinated strategy to it.

Meanwhile, we will continue to vigorously advocate for the issues that can't wait. Our Aged Care Can't Wait campaign will continue to ramp up. The Government cannot blame GPs and use them as scapegoats for its own complete lack of funding in this area. Rhetoric like this will only inflame our relationships and drive more GPs out of visiting aged care facilities, worsening an already fractured service provision.

PHI continues to stagger along in search of a meaningful solution. The November quarter APRA statistics continue to show a trend of dwindling membership. Perhaps this dispels once and for all the notion of doctors being the cause of out-of-pockets and rising premiums. Particularly when we see recent record highs in the no-gap and known-gap statistics (to a combined total of more than 97 per cent).

Public Hospital queues are significantly, but perhaps not surprisingly, ramping up even further, given the increased drop out in PHI membership and surprise budget blowouts confronting some of the States as well. This is a calamity occurring on our doorsteps and under our noses.

Governments still defend record funding amounts, which are never in their wildest dreams going to keep up with the triple drivers or threats i.e. a rapidly increasing population; ageing population; and of course the increasing burden of chronic and complex disease.

This is all at a time when the MBS is hurtling along with an avalanche of work – draft recommendations and implementation groups, yet still no sign of genuine new investment. Rather, ongoing savings are being racked up.

At the same time, further compliance activities are being planned and further legislation proposed in an attempt, you might say, to further unnerve the profession.

All of this at time when economic growth is being highlighted as being at risk, and a wafer-thin budget surplus being protected as we approach both MYEFO and the preparation for next year's Federal Budget.

Now, more than ever, the Government needs to get serious and invest in the infrastructure of our health system and its workforce.

It is the right time and it is need-imperative.

So, is this Government up to the challenge? Early in 2020 the answer will soon become apparent.

Is it time for the AMA to change our advocacy style?

BY **AMA VICE PRESIDENT DR CHRIS ZAPPALA**

I get the impression that AMA leadership for decades has always felt beleaguered with threats to independent, viable medical practice. It is perhaps worse than usual lately. The catalogue of significant threats to our profession include escalating, costly over-regulation with the recent, enervating COAG decision to consider publishing the identity of doctors going through regulatory investigations even if complaints relate to minor matters.

Claiming dwindling private health insurance rates is due to excessive doctors' fees is patently false, but a diversionary conversation health insurers and Government have fostered. General practice remains woefully under-funded and by extension this threatens non-GP specialist practice. The MBS review is slowly taking its toll with the disturbingly dormant timed-specialist consultation issue possibly yet to be resurrected. Scope of practice remains under siege from several quarters. Medical leadership is being devalued and ostracised in the entire health system. Mandatory reporting – what a disappointment. Unfortunately, I could go on....

It is not all doom and gloom. Recently, the AMA was successful in ensuring the future integrity and viability of our medical indemnity system. Unfortunately, many in the profession remain unaware of this. But it has significantly helped every single doctor in this country. This feels like a relatively small win, however, compared to the challenges facing the profession.

It is sobering to consider the efficacy of other advocacy organisations. Pharmacists have dangerously encroached on the role of general practitioners in recent times with initiatives that are clearly unsafe and designed to predominantly fortify the waning retail pharmacy market. Despite the ACSQHC clearly indicating that expanding prescription of antibiotics to non-doctors is misguided, some politicians think the problem would be improved if others were able to prescribe because the genesis of the difficulty relates to undisciplined prescribing by doctors. Clearly ridiculous, but how can such a nonsensical idea even be genuinely entertained? The largest out-of-pocket cost for patients (at 31 per cent) is non-PBS medications and therapies – principally, all of the non-evidence based detritus that help retail outlets make money. But they do not genuinely improve anyone's health (more than any other placebo perhaps would). Government seems blind to this and happy to continue to blame doctors whose contribution to out-of-pocket costs is only 13 per cent! PBAC recommendations are always followed by the Government – it is an independent advisory group. It makes no sense then that the Government has not enacted the change to dispense more than one month of drugs at a time in order to improve convenience and reduce cost for patients. Take also the archaic, protectionist ownership rules that remain in place for pharmacies.

I do believe the brand and voice of the AMA carry weight with the public and Government. Perhaps, however, we need to recognise that this influence has suffered some diminution and dilution in recent years. Our daily discussions between the Secretariat and the Department of Health (and other Government departments), complying with submission requests, media engagement and representation on numerous committees and other forums, has encompassed our traditional methods of advocacy. I do think it is overdue to consider what aspects of this remain effective and what components might be less useful and able to be substituted with new advocacy methods.

At the recent Federal Council, it was suggested that we perhaps need to consider making political party donations. It is not uncommon to see the Pharmacy Guild logo prominently placed at Government events, and the public register of political donors indicates the handsome payments made by the Guild to various political parties. Presumably, this is all part of the Guild strategy to have influence. The key question is should the Federal AMA do the same? I know we never have, and we should not ever. Nor should any member advocacy body. I feel really strongly that you should not need to buy access, but instead argue on merit. If you can't argue on merit, your argument is flawed.

Perhaps easier for us all to contemplate is an evolution of how we lobby politicians. In all of the eight AMAs, we propel Presidents between various meetings but are tending to concentrate on departments of Health (and Government and shadow health portfolios). Decision-making is clearly, however, collective in Cabinet and in the party rooms. So our more focused, time-intensive approach, is perhaps not the optimal strategy. I wonder if we should develop a lobbying group within the AMA, both professional and co-opted from the various councils and general membership, so we can have proficient lobbyists meeting with every single politician who accepts a meeting from us, several times a year. I like the prospect for every politician walking into a party room or cabinet meeting to have been converted to the AMA way of thinking. Methods to widen and enhance our political lobbying efforts and influence should be a conversation we have.

Our AMA Secretariat does a superlative job in responding to the

The system is stretched and needs funding attention

BY AMA SECRETARY-GENERAL MARTIN LAVERTY

Many Australians compare our healthcare system to that of other countries, and rightly feel proud. As a nation we love brand Medicare. We love the idea of universal free access to public hospitals.

We similarly take pride that our health system runs at almost half the cost of the healthcare system in the United States. This is an often-repeated fact, which is again a fact we should be proud of.

The World Bank reports current health expenditure as a proportion of gross domestic product was 17.07 per cent in the United States in the most recent reporting year of 2016, compared to almost half at only 9.25 per cent in Australia.

Implicit in the US-Australian comparison is the message of more from less. It's widely known patients in the United States miss out on medicines and service access to health care that Australians take for granted, yet our system costs only half us much to run.

Focusing on the US-Australia comparison ignores what are possibly more useful comparisons. Australia is often compared to Canada, which spends 10.53 per cent of its GDP on health care. Average health care expenditure across European countries is 10.22 per cent, or across OECD countries is 12.59 per cent.

In Australia, we're surely at the end of more service from less expenditure. Signs of an over-stretched health system have long been present. Yet Governments around the country are more focused on budget surpluses than they are on funding patient outcomes.

Pick a measure, any measure, and evidence of the stretched system is apparent.

Victoria is expecting jumps in public hospital waiting lists next year, at some hospitals by up to 50 per cent.

The Royal Darwin Hospital budget is so stretched its morgue is often overflowing. Grieving families are forced to gather in the heat of a car park rather than somewhere with dignity.

General Practice training places are undersubscribed, again. Low take-up in part reflects insufficient incentives from declining value of the MBS over many years.

It shouldn't be a competition for which State or Territory is worse, but reality is that just about every part of health care is stretched to capacity. Years of forced efficiencies, cost containment, and indexation freezes have taken a toll.

Whenever the AMA or others raise the need for more investment in health, the response of Health Ministers around the country is the same: "Record spending in health!" Yet the record spending claim is a result of population growth. Just to keep up with babies born and immigrant arrivals, new records need to be set each year.

Yet no Health Minister has ever said funding levels have been set to meet the actual cost of care delivery matched to growing population demand. The health system makes do with what it receives, rather than being funded to the level it needs.

With comparable countries spending more on health care than Australia, it's time the funders of our own healthcare system took stock.

Lifting health expenditure to the average of Europe, Canada, or the OECD would likely prevent Victoria's hospital waiting lists blowing out, build a new morgue in Darwin, and provide sufficient incentive to sustain a career in General Practice.

If the AMA doesn't argue for more health expenditure, who will?

Vice President's message ... continued

various requests for submission to committees or in regard to planned legislative change being enacted by Government. This is, however, a very time-intensive undertaking and the thought has uncomfortably occurred to me that the effort required perhaps produces only a very modest benefit, as opposed to widespread lobbying across parliament – which other groups do more effectively than the AMA. As we all enter more stringent financial times, at the very least we must consider what effort is going to produce the greatest benefit for members. I would be very interested to hear what members think on this issue, so please send me an email on czappala@ama.com.au and let me know.

Aged care funding response not enough

The Federal Government has committed $537 million to aged care in response to the Royal Commission's interim report into the troubled sector.

But the AMA, along with other aged care advocates, say the money isn't enough to address growing need or fix the widespread neglect that has been revealed.

Prime Minister Scott Morrison announced a package of $496.3 million for an extra 10,000 home care packages. There are 120,000 people already in the queue.

Earlier this year, the Health Department told the Royal Commission that it would cost an extra $2 billion to $2.5 billion each year to provide appropriate home care packages for everyone on the waiting list.

The new funding also includes $25.5 million towards improving medication management, following the Royal Commission's findings of the overuse of chemical restraints on aged care residents.

New restrictions mean that from January 1, doctors will have to apply for special approval to prescribe chemical restraints.

A further $10 million will be dedicated to training for support of dementia patients, and $4.7 million to help relocate young and disabled people from aged care homes into more appropriate facilities.

Mr Morrison described the process of unearthing horrific accounts from the aged care sector as "a very uncomfortable exercise for all" and promised more funding once the Royal Commission delivers its final report, which is due in November next year.

"I think there are few families around the country, my own included, who are unfamiliar with the difficult decisions that are made about relatives and loved ones who are placed into aged care facilities," the Prime Minister said.

"The funding and structure of these commercial centres, and not-for-profit too, by the way, obviously is impacted by the change in how demand is finding its way into the system.

"A lot of facilities have been built on the long-stay, lower care requirements.

"People sometimes choosing not to take those places up and stay at home and get in-home care places. It's a sector going through a lot of structural change."

Aged Care Minister Richard Colbeck acknowledged that the aged care system and funding model was "generally recognised as not being fit for purpose any longer", as was highlighted in the Royal Commission's interim report.

AMA President Dr Tony Bartone has described the funding package as inadequate, saying much more money was needed to fix the sector.

"The Aged Care Royal Commission has exposed incredible neglect, mismanagement, under-resourcing, and underfunding. Put simply, this money just isn't enough," the AMA immediately responded in a tweeted message.

Council on the Ageing chief executive Ian Yates welcomed the announcement but said the "missing piece of the puzzle" was a

strategy to get the median waiting time for home care packages down from 180 days to 60 days. He described it as “ad hoc”.

Aged Care Crisis spokeswoman Lynda Saltarelli said the announcement was “small first steps” that fall a long way short of the changes needed.

National Seniors Australia spokesman Ian Henschke said the Government had not met the most dire need in the sector.

Shadow Ageing Minister Julie Collins said the funding was nowhere near enough.

“To announce 10,000 packages when the Royal Commissioners have said it is neglect to have 120,000 older Australians still waiting on the home care list is simply not good enough,” she said.

“This is just a drop in the ocean for what is required.”

CHRIS JOHNSON

$496.3m
for 10,000 more home packages

$25.5m
for medication management (chemical restraints)

$10m
for dementia training for workers

$4.7 m
for targets for removing young people from aged care sector

Technological innovations needed for aged care

The AMA has released its latest Position Statement on aged care and says Australia must get innovative in providing sustainable high-quality care for its ageing population.

The Position Statement, *Innovation in aged care*, says with more complex care needs among older Australians, technological innovations are necessary if the level of care is to be improved.

> "Any current and future planning of aged care approaches will require innovative solutions, to reduce the cost burden and improve efficiency in care delivery."

"Older people have a right to live in age-friendly physical and social environments in their home, residential aged care facility (RACF), community, city, and region, that supports independence, prevents social isolation, and includes timely access to services, transport, and infrastructure that enables and supports healthy ageing," it states.

"Digital health, clinical informatics and assistive technologies have the potential to significantly improve the aged care system through increased efficiency and coordination of care providers and by supporting healthy ageing."

Technological innovations are also necessary also to enable the sustainability of the aged care system. The Royal Commission into Aged Care Quality and Safety in its interim report has "uncovered an aged care system that is characterised by an absence of innovation and by rigid conformity" where "innovation is stymied". The Royal Commission called for an increased use of technology in aged care.

The AMA's Position Statement aims to clearly state the AMA's position on the role that innovation in technological developments can play in the improvement of provision of care for older people in aged care settings.

"Any current and future planning of aged care approaches will require innovative solutions, to reduce the cost burden and improve efficiency in care delivery. Future solutions must improve care for older people and either improve or fit the practitioner's workflow so that they do not add a burden of increased workload," it states.

"Increased use of technology requires interoperability between relevant software programs and systems, provided all privacy and security measures are met.

"Further research into incorporating technology in the aged care sector is essential."

The Position Statement outlines the areas where innovation is needed and principles under which that innovation should be developed and implemented, in order to create a system that will benefit both older people and providers of care.

RACFs have the responsibility to continuously strive to improve care, including through technological innovation and that Government funding models should enable and support innovation.

Areas of innovation outlined in the Position Statement include aged care resourcing, electronic records, medication management, assistive technologies, communication technologies, data collection and research, privacy and security.

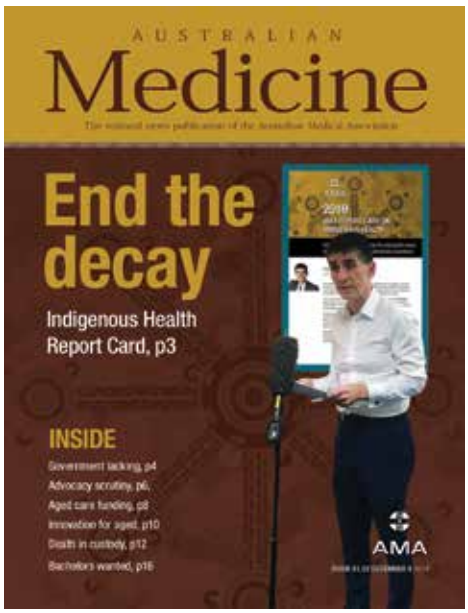
Older people often move between aged care, primary care and acute care settings. Innovation should improve information sharing between these settings and help avoid mishaps that we see happening in aged care.

Additionally, application of digital health to medication management can bring improvements to how medication is prescribed, dispensed and information shared between health care, aged care, and pharmacies, reduce mismanagement of medication and avoid polypharmacy in aged care.

It is the AMA's view that innovative technologies used in aged care should be co-designed with end users i.e. older people, health care and aged care providers, to achieve the best possible outcome for older people. The AMA also places great emphasis on impact evaluations of the application of innovative technologies.

The AMA is concerned with the ethical implications of technology use, data collection and research in aged care, and in this Position Statement is calling for development of timely policies to protect data privacy and security related to older people accessing aged care services.

The Position Statement can be found on the AMA website.



Happy holidays from *AusMed*

This edition of *Australian Medicine* is the last one for 2019.

We will be back early in 2020. In the meantime, keep an eye on the journal's pages (AUSMED) on the AMA website for regular news updates, announcements, and special reports. All of this year's editions can also be found on the website.

Australian Medicine wishes everyone a safe and happy holiday season.

EDITOR

INFORMATION FOR MEMBERS

MBS consultation reports still open for consultation

AMA members are reminded that the following six MBS Review Clinical Committee reports are currently open for consultation until December 20, 2019:

Paediatric Surgery

Cleft Dental Services

Otolaryngology - Head & Neck Surgery

Consumer Panel

Ophthalmology

Psychiatry

The reports are available at the Department of Health's website and these are likely to be the last remaining reports to be released for consultation as the MBS Review Taskforce wraps up its review of the 5,700 MBS items.

As we have echoed throughout the review, the AMA encourages the profession to get involved to ensure they are clinician-led and supported by best evidence. This will be best achieved through providing your feedback directly to the relevant specialty medical Colleges, Associations and Societies (CAS), the MBS Reviews Taskforce and/or through the AMA.

If AMA members would like the AMA to advocate on significant issues arising from the above MBS Review clinical committee reports please email tvo@ama.com.au as soon as possible.

AMA stands with Indigenous community over death in custody

Dr Bartone speaks to the media while in the Northern Territory.

AMA President Dr Tony Bartone has expressed the AMA's condolences for the death in custody of Warlpiri teenager Kumanjayi Walker.

The 19-year-old was shot on November 9 in his own home in the town of Yuendumu, a remote community on the edge of the Tanami Desert.

He was then taken to a police station with no medical officers in attendance, where he died before an ambulance arrived.

Northern Territory police constable, 28-year-old Zach Rolfe, was subsequently charged with murder.

Visiting the Northern Territory later in November, Dr Bartone said the AMA mourned the death of Mr Walker and expressed its condolences to his family and to the Yuendumu community.

He said too many First Australians have died or been mistreated in the criminal justice system.

"Almost 30 years on from the Royal Commission into Aboriginal Deaths in Custody, First Australians continue to die needlessly," Dr Bartone said.

"The landmark Royal Commission, that ran for six years from 1987, identified institutional racism within the criminal justice system as the key contributor to harm and avoidable deaths of Aboriginal and Torres Strait Islander people. It appears little has been learnt."

The Australian Indigenous Doctors' Association petitioned the AMA Federal Council to stand with the people of Yuendumu as the community grieves the death of Mr Walker. The AMA Federal Council, in response, unanimously expressed support for Mr Walker's family and his community.

"The tragic death of Mr Walker is now a matter for the courts. The known circumstances of Mr Walker's death have impacted around the nation. Sadly, the circumstances are all too familiar," Dr Bartone said.

"It appears that at the time of Mr Walker's death, health services were not immediately available in Yuendumu, illustrating the practical challenge of health service delivery in remote communities.

"While the courts will deal with the facts and consequences of Mr Walker's death, we as doctors have to ensure the criminal justice system always protects lives and avoids harm in undertaking law enforcement.

"Doctors must speak out where health service access is either insufficient or not robust. There are often good reasons why health professionals are not available, or have to leave remote communities, but adequate alternatives must always be in place.

"Across Australia, more work is needed to address racism and unconscious bias in every government agency delivering a service to Aboriginal and Torres Strait Islander people.

"Within the Northern Territory, it's also time to review the adverse mental health impacts of the Stronger Futures Act 2012. The Act allows police entry to private homes without a warrant or consent of the residents. This leaves some residents fearful of living in their own homes, and adversely impacts mental health," Dr Bartone said.

The Police Federation of Australia condemned the murder charge against Constable Rolfe, saying police officers around the country are "undoubtedly shocked" by the charge.

In a statement, the PFA described the shooting as an "incident in the course of his duties" and said the Northern Territory Police Association will fully support the constable and his family. It will provide full legal representation.

Constable Rolfe intends to plead not guilty and contest the charge.

CHRIS JOHNSON

Cave rescue's hero doctor gives dramatic account

> "The rescue operation was fraught with tense moments, with one rescue diver losing grip of the guide rope and getting lost in the turbid water."

Stunning details of the dramatic rescue of 12 young soccer players from a flooded cave in Thailand in 2018 has been revealed in a candid and in-depth interview with rescue diver – recipient of the AMA Gold Medal, Dr Richard Harris SC OAM.

Dr Harris was hailed a hero for risking his life in the successful retrieval operation.

A Flinders University medical graduate, expert cave diver and specialised anaesthetist, Dr Harris was joined by popular Australian science personality Dr Karl Kruszelnicki AM for Flinders University's annual Investigator Lecture earlier this year.

In front of a captivated, sell-out crowd at Adelaide Town Hall, Dr Harris revealed dramatic details from behind the scenes of the rescue operation that saw the young soccer players — aged from 11 to 16 — and their coach medically sedated, fitted with full-face diving masks, and brought through the flooded cave network to safety by a team of 19 diving rescue experts.

The interview video is now available on Flinders University's YouTube channel at https://www.youtube.com/watch?v=-Hktu5qmT7g

Dr Harris explained many of the technical difficulties that made the rescue operation such a logistical challenge; such as finding the right model of specialised scuba mask that would provide constant positive air pressure, allowing the boys to breathe while anaesthetised and under water.

"There were hundreds of masks sent from all around the world; the US military bought a heap of them; the Australian Federal Police had some. Dive shops from all around... were sending masks. (There was) one model with this particular function, and there were only four of them," Dr Harris said.

The rescue operation was fraught with tense moments, with one rescue diver losing grip of the guide rope and getting lost in the turbid water.

"He basically spent 15 minutes swimming around, with no visibility, with his child starting to wake up. Completely off the line, didn't know where he was, gas running out," Dr Harris said.

Officially closed since the 2018 incident, the cave network in Thailand's Tham Luang National Park was only recently reopened, with more than 2,000 tourists visiting the site.

Dr Harris and fellow Australian diver who partnered him in the successful cave rescue, veterinary surgeon Craig Challen SC OAM, have also written a book of the account called *Against All Odds*, published by Penguin Random House.

Do you have a business plan for your practice?

CommBank's GP Insights report examines how Australian GPs can grow their practice to align with changing patient preferences.

Find out more at commbank.com.au/healthcare

[1]CommBank's GP Insights Report 2019, available at commbank.com.au/healthcare

Can

New My Health Record guide for ED doctors

With more than 22 million Australians now having a My Health Record, a suite of clinical tools and resources has been developed by the Australian Commission on Safety and Quality in Health Care in partnership with the Australasian College for Emergency Medicine (ACEM.)

Recently released, the resources include a guide for emergency department clinicians, with practical information on accessing up-to-date My Health Record data for people requiring emergency care.

More than 40 per cent of ED presentations occur out of normal business hours. The My Health Record system can support hospital clinicians to access patient information out-of-hours and from outside their local hospital network.

The *Emergency Department Clinicians' Guide to My Health Record* is now available.

The guide describes the types of clinical documents that may be included in a patient's My Health Record and the origin of that information. There is also a focus on protecting vulnerable patient groups and legislative requirements that ED clinicians need to be aware of.

Emergency physician Dr Andrew Hugman is the Commission's Clinical Lead on the project.

"Immediate access to additional information about a patient's medical history can be crucial in time-critical settings such as EDs," he said.

"My Health Record facilitates clinicians' viewing of material that is otherwise hard to see outside of their regular hospital network. It's not surprising that there is increasing interest among ED clinicians to better understand the system.

"Ultimately, the better informed the clinician, the better the decision making about their patients' care. Australian health care is in the midst of a digital transformation, so it is essential all clinicians are made aware of how we can use digital innovation to achieve the best outcomes for our patients.

"This new guide explains the 'what' and 'why' of My Health Record to ED clinicians and where it can fit into their current practice. It has been written for clinicians by clinicians."

There has been a significant increase in the amount of clinical information flowing into the My Health Record system since February 2019. The rapidly expanding system already contains more than 3.4 million shared health summaries, 37 million prescriptions and 22 million pathology reports.

The guide and other new resources and information can be found at: https://www.safetyandquality.gov.au

Bachelors with stethoscopes wanted

Warner Brothers Australia is on the lookout for The Bachelor 2020 and is quite keen to find a doctor.

While anyone they consider suitable from any profession or industry is welcome to apply, sources tell us they would so love to find an eligible doctor.

A scoping phone call from Warner Brothers' casting team all but confirmed as much.

"We are currently searching for **The Bachelor 2020** and I wanted to see if you could think of anyone involved within your workplace who would be suited," a follow-up email stated.

"Even if you think of anyone outside of your workplace, they are most welcome to apply!"

Producers are looking for single men aged between 27 and 40.

"Are you the next Bachelor? Want to join us for an action-packed ride?" their message said.

"An experience like no other that will blow your mind! You could even meet the love of your life."

Filming takes up to 12 weeks between February and May next year.

Applications can be made at: https://go.mycastingnet.com/Apply/Show/Bachelor

Good luck guys ... and don't forget to wear your AMA cap.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

WITH CHRIS JOHNSON

Climate change and health should be priority area, Bowen

Shadow Health Minister Chris Bowen has called for climate change and health to be established as a National Health Priority Area.

In a speech delivered at the University of Sydney, Mr Bowen said he was amazed by the number of doctors who had talked to him – in the six months since taking on his new portfolio on the Opposition benches – about the health impacts of climate change.

"As one senior doctor put it to me powerfully recently 'doctors listen to the science of the climate change and its health impacts like we listen to the science of vaccination and the impacts of not vaccinating. They are as clear as each other, and ignoring the science of climate change would be akin to supporting anti-vaxxers'," he said.

"The problem is that this sense of urgency amongst our clinicians is not reflected in Government policy. The word 'climate' is not mentioned in our Department of Health's Budget papers."

National Health Priority Areas are action plans agreed between the Commonwealth and the States and Territories for urgent priority health issues. The status raises awareness, defines the challenges, and sets out a road map for dealing with them.

There have been ten priority areas: cancer control, cardiovascular health, injury prevention, mental health, diabetes mellitus, arthritis, musculoskeletal conditions, obesity, dementia, and the quality and safety of medicines are all priority areas.

"What is often missing from the public debate in Australia is an understanding that severe climate change, of the type the globe is currently on track to experience, isn't just about the frequency and severity of weather events, it is about changing climate zones, desertification, ocean acidification, ecosystem collapse; these impacts threaten our food supply, our economy, our security and of course our health," Mr Bowen said.

"As some have put it, climate change is so dangerous to health that it threatens to unwind 50 years of progress in improving public health outcomes, as well as adaptation to already unavoidable impacts from climate change."

New PBS and ARTG listings

Australians living with non-small cell lung cancer and early stage acute lymphoblastic leukaemia will be able to access better treatment options with new listings on the Pharmaceutical Benefits Scheme (PBS).

More than 2,200 patients with metastatic non-small cell lung cancer will now be able to access Keytruda® (pembrolizumab) as a first line treatment in combination with chemotherapy.

"This means most patients will not have to fail treatment with chemotherapy before accessing this game changing treatment for this condition," Health Minister Greg Hunt said.

"Patients may have otherwise paid up to $120,000 a year depending on their specific cancer subtype."

The existing listing of leukaemia medicine Blincyto® (blinatumomab) has also been extended from December.

Blincyto® will now be available for the treatment of patients in the early stage of acute lymphoblastic leukaemia, but have minimal residual disease (MRD).

A patient has MRD if they respond well to initial chemotherapy but a small number of cancer cells can still be detected.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

"Without PBS subsidy, approximately 86 patients would pay up to $150,000 for each course of treatment," the Minister said.

AJOVY® (fremanezumab), is now listed on the Australian Register of Therapeutic Goods (ARTG) for the prevention of migraine in adults.

It is the first and only treatment in its class with two dosing options, with quarterly (675mg) and monthly (225mg) dosing available.

The ARTG listing is based on results from a pivotal double-blind, randomised, Phase III clinical trial of adult patients with chronic migraine that showed a significant benefit of the drug over placebo in reducing the number of headache and migraine days per month.

This product is not listed on the PBS.

Minister launches phase two of suicide prevention research

Black Dog Institute

As part of its 'Towards Zero' suicide prevention goal, the Federal Government has launched phase two of the Black Dog Institute's Centre of Research Excellence in Suicide Prevention (CRESP II).

Supported by a $2.5 million taxpayer investment, the centre's research will focus on the early detection of Australians at risk of suicide.

Funded through the National Health and Medical Research Council (NHMRC), the centre, located in Sydney, brings together researchers from six universities to work towards this goal.

Health Minister Greg Hunt said the centre will implement a coordinated and multifaceted intervention strategy to detect people at risk of suicide earlier.

"Supporting Australia's research in suicide prevention is critical in reducing the number of lives lost to suicide," Mr Hunt said.

"This is a significant opportunity for Australian researchers to focus on real time suicide risk detection and prevention, providing outcomes that aim to reduce suicide rates."

The strategy will involve the delivery of evidence-based interventions in six different contexts: schools; workplaces; online; healthcare; means restriction; and crisis and aftercare.

The centre will use smartphone and sensor technology to revolutionise prediction and response systems, by providing real-time information about suicide risk and delivering timely interventions.

The research will be led by Scientia Professor Helen Christensen AO, who is a leading expert on using technology to deliver evidence-based interventions for the prevention and treatment of depression, anxiety, suicide and self-harm.

The Minister said phase two of the centre was a critical investment that would ultimately "save lives and protect lives".

Private health insurers told no

Health Minister Greg Hunt has told private health insurers that their proposed price rises are too high.

The Minister has written to the insurance companies telling them they should rethink their premiums and resubmit their applications for the 2020 price rises.

The insurers have asked for an increase of 3.5 per cent – higher than the 3.25 per cent granted in 2019.

"I have written to private health insurers, asking them to deliver lower premium changes for consumers," Mr Hunt told the *Sunday Telegraph.*

"Their proposed changes for premiums in their first applications were too high."

The insurers are not happy.

Private Healthcare Australia CEO Rachel David told the newspaper: "Health funds will do what they can to meet the Government's target but it will be challenging, and mean that health funds will have to be tough on wasteful medical device claims and there will be no room to move in contracts with providers."

Ensuring the line between prescribing and dispensing is maintained

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

Imagine your patients understood their prescribed medications, what each one does and why compliance with the dosage regime is important. Imagine your patients understood what over the counter complementary medicines might be contra-indicated. Imagine reducing the adverse drug events experienced by your patients. Imagine patients' access to vital medication could be improved.

> "While this is a good start, the policy is limited by the retention of current caps on incentive arrangements and the lack of indexation that has eroded the value of these types of subsidies."

The AMA understands the importance of these things to quality patient care, and in 2015 released the AMA's *General practice pharmacists – improving patient care* proposal. Evidenced-based and developed in consultation with the Pharmaceutical Society of Australia (PSA), this proposed a funding program for integrating pharmacists into general practices and outlined the economic benefits as well as the potential for improved patient outcomes.

Our advocacy for this proposal successfully resulted in the Federal Budget 2018-19 announcement that general practices, regardless of location, would be supported to employ allied health professionals, such as non-dispensing pharmacists within general practice. The changes, under the new Workforce Incentive Program (WIP), will commence early in 2020. From February 1, general practices will be able to access subsidies to further support them to build their multidisciplinary healthcare teams. While this is a good start, the policy is limited by the retention of current caps on incentive arrangements and the lack of indexation that has eroded the value of these types of subsidies. This needs to change if we are to fully realise the benefits of multidisciplinary care with general practices.

More recently, the AMA has been working on an advocacy strategy to promote the role of pharmacists in general practice, while providing patients with enhanced convenience, safety and quality care in access to medications. Coupled with this has been the AMA's ongoing efforts to ensure patient safety and quality prescribing. In October, we released the *10 Minimum Standards for Prescribing*. Developed by the AMA Council of General Practice and approved by the AMA Federal Council, the Standards are consistent with medical ethics and frameworks for the quality use of medicines.

These Standards put the interests of patients first and provide strong evidence to reject attempts by unauthorised or inappropriately skilled practitioners who may seek prescribing rights outside of their scope of practice. With the release of the Pharmacy Board of Australia's Position Statement on Pharmacist Prescribing that same week, it was reassuring to see patient safety trumping pecuniary interest with the Board taking a position to not pursue a model of autonomous prescribing by pharmacists.

There are simple changes that Government could make now that would provide patients more convenience and enhance affordability of medications. Most predominantly, enabling pharmacies to dispense up to three months' worth of a medication at a time where deemed safe to do so by the prescribing medical practitioner. Other reforms that will be explored in an AMA discussion paper in the coming year will include deregulation of pharmacy ownership, innovative models of dispensing utilised overseas, and the use of enabling technology to facilitate medication dispensing that is safe, timely and convenient.

The discussion paper will highlight that GPs want to improve patient access to medications in a safe manner. A key principle will be ensuring the line between prescribing and dispensing is maintained.

So, while the new year will no doubt hold some hot debate on the above-mentioned issues, now I'd like to take this opportunity to wish you all a happy and safe holiday season.

Peace and happiness

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

Recently, I had an experience which left me feeling exhilarated!

My wonderful colorectal surgeon, who relieved me in February this year of seriously affected large bowel segments diseased with diverticulitis, called me. "Why are you scheduled for a colonoscopy next Wednesday?" she asked.

"I thought you arranged it," I said.

"I usually like to follow-up a year after surgery, unless you have symptoms." Truthfully, I was doing well, and we exchanged Christmas greetings and agreed to meet in February. Santa had come early.

In a recent poem entitled *President's Day*, American poet Louise Glück writes of the experience of walking in 'good-natured sunshine' after snow. It makes her head joyful, she says, 'basking in it, getting to feel it first while the limbs waited'. Then she reflects, '*Joyful* – now there's a word/we haven't used in a while.' Two recent reports tell us about the state of peace and happiness in the world today.

The *Global Peace Index*, the thirteenth edition of which – for 2019 – was published recently by the Institute for Economics and Peace, ranks 163 states and territories 'according to their level of peacefulness'. It uses 23 indicators. The Index has three domains – *Societal Safety and Security, the extent of Ongoing Domestic and international Conflict*, and the degree of *Militarisation*.

Good news! This year the Index improved for the first time for five years – by about 1 per cent, with 86 countries improving and 76 deteriorating. Iceland, New Zealand, Austria, Portugal and Denmark top the list. Australia ranked 13th.

Since 2008, the Index has fallen by 4 per cent across 17 of the 23 indicators. Paradoxically, since 2008, the *Militarisation* indicator has improved by 3 per cent, with military expenditure as a percentage of gross domestic product falling in 98 countries. The *Societal Safety and Security* domain is especially sensitive and small deteriorations in it, due to corruption, inequality and declining economic performance, can tip the Global Peace Index downwards. When these factors are absent, gross domestic product – GDP – goes up.

Of the estimated $14.1 trillion (purchasing power parity dollars) impact of violence on the global economy, there was nevertheless an improvement during 2018 of 3 per cent, with a 29 per cent decrease in economic loss 'due to reduced intensity of conflict in Syria, Colombia and Ukraine.'

If this is the global state of peace, how happy are we? The *7th World Happiness Report* is another complex document based on detailed international comparisons of GDP *per capita*, healthy life expectancy, social support, freedom to make life choices, generosity, perceptions of corruption, positive and negative affect. Data are drawn principally from the Gallup World Poll. These variables explain roughly half of the overall evaluations of happiness. All the other things – often specific to a country or individual – make up the other half.

At the top is Finland, then Denmark, Norway and Iceland – recall its high ranking for peace as well. New Zealand comes eighth, Canada ninth, and Australia 11th out of 156 countries. South Sudan comes last. The US is 19th.

What of the future? The Happiness Report contains a chapter on Big Data, which symbolises tomorrow. The pace of change here is beyond comprehension. Google queries went from 14 billion in 2000 to 1.2 trillion in 2010. Big Data – large datasets that contain multiple observations of individuals – and we cannot calculate the effects they will have on individual freedom or happiness. But the guess is – profound. Big Data from Twitter in Mexico allow us to see 'the large positive mood swings on particular days, like Christmas 2017 or the day that Mexico beat Germany in the Football World Cup 2018, and the large negatives, like the earthquake in 2017, the loss of the World Cup against Brazil, or the election of Donald Trump in the 2016 US Election'.

All very well, but in a recent essay in Aeon, a Web site, Cody Delistray, a writer and historian based in New York and Paris, challenges us with the question "How did feeling good become a matter of relentless competitive work; a never-to-be attained goal which makes us miserable?" He laments:

> *Today, market research ... has only continued to grow, pioneering in-store face scanning – to determine consumers' emotions in front of certain products – advertisements that seem to follow us across every digital platform, and, eventually, the Holy Grail of market manipulation: being able to create products that hack our happiness, that make us neurologically need to use and buy them.*

As an alternative we were to accept that happiness ebbs and flows, that 'negativity is fundamental to life and, ironically, to our happiness? What if we reconditioned ourselves: not to want but to be satisfied in all feelings'.

This may be wishful thinking, but it is a helpful perspective for us and for our patients. Mind you, I'm still happy about that cancelled colonoscopy, although I know February is close!

A peaceful and happy Christmas!

A rural practice is a tough business

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

> "My business failed. I am not trying to pass the buck, but my business did not fail due to lack of effort or hard work on my part – it failed because of the market, or lack of one."

Last month I became an Australian citizen. It was a long but worthwhile journey (special thanks to my fellow GP and AMA ACT President Dr Antonio di Dio for coming along to the ceremony). Though I am now an Aussie, I will still be an international medical graduate. The AMA has been a great support for me as an IMG and will continue to be.

Long before I came to Australia, I built a solo general practice. A private business complete with all the books and ledgers, the constant struggles to find locums, arranging the staff payroll and leases. This was time consuming, but I loved my job and my practice and my community.

I was a do everything family physician providing provided cradle to grave care. I had hospital privilege, visited nursing homes, made some house calls to palliative patients, obstetrics to 36 weeks, I did all the childhood immunisations and if my patient was taken to surgery, I insisted that I be the surgical assist. IUDs, lumps and bumps were routine. I worked late – to 8 PM to accommodate my patients' work hours. I took my own after hours call and also was on a call roster as a sexual assault forensic examiner.

My business failed.

I am not trying to pass the buck, but my business did not fail due to lack of effort or hard work on my part – it failed because of the market, or lack of one.

I failed as a business owner because:

1. I spent too long with each patient. To break even, one needs to see about one patient every 10 minutes, nonstop. To make a profit, that time needs to be cut down to six minute medicine*.
2. I provided full services, many not compensated for. I did this because I was a doctor who wanted to provide the best care my patients needed. It was charity.
3. I spent a lot on equipment and outfitting a practice – very expensive when not shared.
4. I was on governance bodies (like our GP Colleges here), subcommittees of mental health and immunisation protocols. This was essential work, but it was not paid.
5. My morning hospital rounds barely covered the cost of fuel for my car to get there.

This happened to me in Canada, but the experience is not too different from many that I hear when I speak with rural GPs – running a private practice is not financially viable. Years of the Medicare rebate freeze really hurt rural GPs who have populations that are less able to pay the gap. There are few solo and small practice GPs in rural Australia. Private businesses. And they are dying. This has been overlooked in most of the recent efforts to increase the rural medical workforce, such as the National Medical Workforce Strategy, and that needs to be changed.

Consider this scenario: You are a doctor finishing your intern year considering rural generalism because you had a great time on your rural placement and want an exciting career. You look at your options down the path and see post-fellowship the opportunity of buying into a general practice, but that general practice is failing. The town needs a doctor though. What do you do? Do you take on the burden of a struggling business just to have the privilege to work in this town? Or do you look for another way?

There are other considerations for doctors considering going rural. The cost of running a business is more than monetary, it absorbs your time, keeping you away from family and a work-life balance. Young doctors and medical students see this – general practice, particularly rural, is not seen as providing a work-life balance that the new generation of doctors want. The financial compensation is the same with fewer hours and smaller sacrifices in your personal life in a non-rural location.

A rural practice is a tough business ... continued

Yet we need private businesses, it is this private business that is the foundation of the family doctor. We need a medical home with the mandate of primary care. This is what patients need. A Norman Rockwell family doctor.

Primary care needs to be treasured, especially in locations where the health differential is greater. Thorough, preventative, continuous care is what counters loss of follow up, preventable hospital admissions, increased rural morbidity and earlier rural deaths.

How can we recognise these treasures, the struggling GP in in a private business?

We can begin by acknowledging that many private general practices in the country are unlikely to find another GP or rural generalist to buy in to the practice. The AMA's Easy Entry Gracious Exit position statement is a potential solution, but there are other options to help support these practices, and we would like to see them discussed in the National Medical Workforce Strategy.

What do you think about these?

- rural differential MBS Billings;
- increased Rural incentive payments;
- tax-free infrastructure grants;
- equipment subsidies;
- paid holiday time off;
- retirement Savings contributions;
- indemnity assistance;
- subsidised CME;
- housing, electricity, transport subsidies; and
- allied health and specialist support.

* *In Canada it is illegal to charge a gap. The billings are not time-based.*

Suspect your patient has been concussed?

Familiar with the diagnosis of concussion?

Recognising concussion can be difficult. The symptoms and signs are variable, non-specific and may be subtle. Use the latest evidence-based information to better recognise, manage and diagnose concussion in sport related injuries.

Sign up for the 'Recognition and Management of Concussion' in Sport module today: dplearning.com.au/cpd-learning/recognition-and-management-of-concussion-in-sport

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EMR: friend or foe?

BY DR BERNADETTE WILKS, CO-CHAIR, COUNCIL OF DOCTORS-IN-TRAINING

By now, most have been exposed to the electronic medical record (EMR), also known by a number of related terms such as electronic health record (EHR) and electronic patient records (EPR). I have presented twice within a fortnight on the topic of EMR, with a focus upon the EMR's impact upon medical education and training. However, like all things in medicine; this impact is not limited to teaching and training but extends across all industry domains; from morbidity and mortality, hospital productivity, ethics, privacy and confidentiality, patient satisfaction, physician well-being and team dynamics.

Feedback from both presentations illustrated high levels of frustration and fatigue associated with EMR implementation and use; and minimal awareness about EMR's multidomain impact. The consensus from both presentations was that EMR discourse must remain front and centre during these tenuous years of implementation and complete integration into our healthcare system.

EMR was first propositioned as a legitimate replacement of paper records in the early 1980s and by 2004 the need to convert medical records from paper to screen became a priority. Despite the passage of years, EMR is still in a nascent form; hampered by financial, time-related and technical factors; as demonstrated by two systematic reviews in Canada, one in 2009 and a follow-up in 2014.

I will provide a multidomain 'impact report'; by no means complete, but I hope readers will conclude, to quote Mark Twain, "there was food for thought there".

Training

Ineffective, inadequate and time-consuming EMR training is a continued bugbear of clinicians where all are deemed computer novices who need to complete all possible EMR tasks. Seven hours of indiscriminate training has proven ineffective; time and time again, but this mode of training continues to be mainstay. The Fiona Stanley Hospital in Western Australia demonstrated marked improvement in EMR literacy with specific task and ward-based training. Competency at a few key role-specific tasks was assessed via mouse click numbers and time to task completion. Another overseas study demonstrated that simulation-based training, with immediate feedback on key learning objectives, increased EMR adoption by 70 per cent.

Go-Live

It is a chilling statistic, but patient mortality and morbidity increases for up to 12 months during EMR implementation; as published by BMC Medical Informatics and Decision Making. Factors were multifactorial but included poor training and software design. Furthermore, there is a global hospital productivity dip that can last for as long as 18 months during the EMR Go-Live period, irrespective of whether there is a phased EMR implementation, or the so termed 'big-bang' implementation.

Prescribing

EMR drug prescribing is frequently the first EMR capability to be adopted, offering a number of benefits over paper charts by circumnavigating illegible handwriting, providing warnings about potential drug interactions and reminders if drugs are overdue. However, alert fatigue can result in these warnings being ignored, or automation bias can result in genuine alerts being dismissed.

Ward Rounds

During ward-rounds, the EMR can impede multidisciplinary exchange, as the once communal paper chart is now under the sole ownership of the one standing at the Computer on Wheels (COW), whose ergonomics creates unequal information access.

This sole ownership can disincentivise consultants from probing their juniors for information, as the consultant can quickly access all notes with a few clicks. Some medical students report internship ill-preparedness, as the opportunity to practice notetaking during ward rounds becomes impractical, as medical students infrequently have EMR logins. Furthermore, it can be challenging for consultants to determine a trainee's competency, as a trainee who is EMR proficient may ipso facto appear clinically competent with no correlation to their knowledge or clinical reasoning.

Notes

But it is not all EMR doom and gloom. A number of DiTs report increased consultant feedback on their EMR discharge summaries compared with paper equivalents. And EMR notes are frequently rated of higher quality and with greater details, especially notes pertaining to pain and mobility assessments. That is, as long as notes are not needlessly inflated with volume and irrelevant content; or with perpetrated errors from copying and pasting previous entries.

Time

Time spent on EMR documentation is dependent upon post-graduate year, time of the year and most interestingly, sex. Males DiTs spend 25.2 hours weekly to females' 15.6 hours; and interns spend 41.4 per cent of their week compared with PGY +4 who spend 28.8 per cent of their working week on EMR documentation. Compare all of these numbers with the ~22 per cent of time on documentation when paper charts predominated.

Education

EMR can provide excellent 'just-in-time' education through ready access to point-of-care knowledge, up-to-date information, guidelines and algorithms; all of which would otherwise be added to a long after work to-do-list of things to look up. Ease of remote EMR access equally has pros and cons. Trainees can look up patients for the following day's theatre schedule without coming in on a day off, but this can creep into the expectation of a 24-hour knowledge of patients' investigations and progress.

Burnout

There is an emerging 30 per cent rule with EMR: >30 per cent of clinical time is spent on EMR, 30 per cent of EMR use occurs outside of paid and rostered work hours and there is a 30 per cent higher burnout rate with EMR use. In November of this year, the Mayo Clinic published a strong dose-response relationship between physician burnout and poor EMR usability; using a standardised metric of technology usability, with EMR usability being awarded an F.

Patients

Patient centredness is one of the first negative sequalae of EMR use as the dyadic doctor-patient relationship has become triadic where an interactant, the computer, must be incorporated into the consultation to prevent alteration of the power and authority between patient and doctor. A number of EMR specific skills have been advocated to reduce the impact of the EMR; everything from learning to touch-type, to signposting the transition between reviewing, writing and interacting. But how these skills will be acquisitioned has yet to be enumerated and may need incorporation into medical school curriculums.

Privacy

EMR privacy and security has been rated a low concern for clinicians but a high concern for patients, to the point that patients may delay hospital presentations or withhold information. At one Victorian hospital, all medical staff received an email to say the EMR had been inappropriately accessed by staff and was therefore a potential significant breach of privacy, risking formal legal penalties. Has accessing medical record behaviour changed between paper notes and EMR implementation, or has the ease of monitoring medical record access via EMR, inadvertently exposed clinicians to formal penalties without adequate education to smooth the transition?

I hope this snapshot of an emerging and current dilemma will encourage increased and ongoing discourse, research, out-reach and a pre-emptive approach to the EMR sleeping dragon.

Changes to the way you prescribe – Electronic and Active Ingredient Prescribing

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

The 2018-19 Budget announced important changes under the Electronic Prescribing Budget Initiative. This includes initiatives for Electronic Prescribing (ePrescribing) and Active Ingredient Prescribing (AIP). From October 31, ePrescribing and AIP were enabled under legislation. This is a positive move the AMA supports.

ePrescribing will allow patients to receive their prescriptions in an electronic format as an alternative to paper-based prescriptions. Generally, the prescribing process for doctors will not alter greatly – clinical software programs will still issue a prescription. Some decrease in administrative burden is anticipated as doctors will no longer be required to print and sign a prescription. The additional benefit to patients is how this might shorten the supply chain for medications and circumvent or reduce trips to the retail pharmacy. As the healthcare sector (slowly) becomes more digital, hopefully there will be a concomitant increase in convenience and affordability for patients. Provided patient safety and evidence-based doctor-centered care is not fragmented or compromised, both parties (doctor and patient) should gain advantage.

ePrescribing is in its infancy. Software providers are currently developing programs to conform with the technical framework set out by the Australian Digital Health Agency. ePrescribing software is being developed under a set of eight principles which aim to:

- ensure patient information is safe and secure,
- maintain patient choice in their prescriber/pharmacy, and
- whether they opt for a paper-based or ePrescription, ensure that ePrescribing aligns with existing Commonwealth, State and Territory legislation, and other important frameworks, policies, and infrastructure.

ePrescribing is expected to be available from the first quarter of 2020, so please check with your software provider when this will be available for you and your patients.

AIP is the second project under the Electronic Prescribing Initiative aims to increase the uptake of generic and biosimilar medicines, with a view to making the system financially sustainable. As you know, many patients recognise their medication by the brand name (if they recognise the drugs they are on at all!), and there can be a risk of incorrect dosing if they take multiple medications that contain the same active ingredient, through brand substitution, or perhaps even omit doses due to confusion or lack of recognition. We are all familiar with the burden of medication errors in our healthcare system. Therefore, the AMA has taken a close and positive interest in the development of this initiative.

The *National Health (Pharmaceutical Benefits) Regulations Amendment (Active Ingredient Prescribing) Regulations 2019* requires that active ingredients are included by default on all Pharmaceutical Benefits Scheme (PBS) and Repatriation (RPBS) prescriptions. This requires clinical software providers to update their software. More than this, it would make sense for this active ingredient recognition to flow through to Webster Pack information and package labelling – but this latter step will hopefully occur by assimilation as patients become more confident with their medications and the changes outlined above become established.

There are some exceptions, however. Handwritten prescriptions, paper-based medication charts in residential aged care facilities, and medication with four or more active ingredients are excluded. Doctors will still be able to prescribe by brand (noting the active ingredient must still be on the script) if the doctor considers this necessary for the medical treatment of the patient. In addition, the 'do not substitute box' is still available to be ticked. Perhaps the slight tendency for this box to be ignored at dispensing will diminish as patients become more empowered and aware of the exact medications they are prescribed.

Although the legislation is already active, there is a transition period until October 31, 2020. There is still time to familiarise yourself with the changes. This is important to do as the prescriber is responsible for ensuring the prescription is written in accordance with the new legislative requirements. It is also important that you guide your patients through these changes to avoid any confusion regarding the name of their medication. The Australian Commission on Safety and Quality in Healthcare will be developing Australian Guidelines for AIP and clinical guidance on which medicines should

be prescribed by brand and which medicines are excluded from AIP when it relates to patient safety or practicality.

The AMA has been engaging closely with the Department of Health and the Australian Digital Health Agency to develop these initiatives, including participation in technical working groups. AMA engagement has provided timely opportunities to raise concerns AMA members have regarding these initiatives, but also medicines more broadly.

For example, my colleagues report that too often their decision to prescribe a particular brand has been overridden by the pharmacist. There are good clinical reasons why generic or biosimilar medicines are not appropriate for some patients, and the AMA has called on the Government to uphold appropriate compliance measures to prevent pharmacists from not upholding the doctor's direction. The AMA also sought assurances from the Government that there will be no additional administrative burden accompanying the changes, doctors will be appropriately engaged, and that active ingredient labelling on medication boxes should be larger than the brand name.

Overall, the AMA is pleased to see these innovative initiatives come to fruition which continue to progress the medical profession through a digital age. One of my next challenges for our association is to develop assistance tools and training that help practices becomes more efficient and digital. Our overarching aim should always be to make the working life of doctors a little bit easier. Please contact the AMA if you have any ideas to help us achieve this for you. Or I can be emailed at czappala@ama.com.au

Money, money, money

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

'Students love free food' is a time-tested adage, often luring medical students into grand rounds. During a placement to a larger metro hospital last year, I recall marvelling at a friend who had worked out where to get free lunch every day of the week by attending different departments' teaching sessions. While this was likely one determined student's solution to not needing to pack lunch every day, the unfortunate reality is that many medical students are being left behind due to the financial difficulty of completing their degree.

This year, Medical Deans reported that 73 per cent of graduating medical students relied on family support for their income, an increase from 68 per cent in 2014. Additionally, 53 per cent of students were employed as they studied, an increase from 49 per cent in 2014. Students are needing to find more sources of income to study medicine.

In addition to direct course fees, medical education, along with several other health courses, entails additional costs outside the lecture theatre. Clinical placements bring a great deal of learning, often at distant satellite hospitals; unless you're lucky enough to be placed exclusively at hospitals with reasonable public transport, a car is a necessity. In 2017, I moved to Campbelltown specifically to live across the road from my main teaching hospital, only to have six of my nine placements at least a 40-minute drive away. And good luck finding cheap parking! There are particular subsets of medical students that will face unique challenges. Students on rural placements, of variable length, run into dilemmas with housing costs: while some universities offer free or subsidised accommodation others expect the student to be solely responsible. Some students need to continue paying rent in their usual place of residence, and many will forego income from their usual job. The vast majority of medical students under the age of 22 do not qualify for independent Centrelink payments, which requires 18 months of full-time paid work; an untenable bar to achieve while studying medicine. On the other end of the age spectrum, older and/or post-graduate students are entering medicine with existing debt. Some also have partners and children to support as they study. Full-fee paying students, even with FEE-HELP, can be left paying hundreds of thousands upfront in tuition costs.

Even the cost of applying to medicine is a costly endeavour, adding together the UMAT/UCAT, GAMSAT, GEMSAS and travelling across the country for medicine interviews, especially for those who go through this process multiple years before getting into medicine.

This financial burden leads to stress and poor academic performance. 26.6 per cent of medical students respondents to a BeyondBlue survey identified finances and debt as a source of stress upon their mental health. Each exam season, I gamble on how many weeks I can take away from my part-time job before they get sick of me. During my most intensive rotation, I worked 20 hours each weekend to avoid clashing with an unpredictable clinical schedule which had supervisors asking me to stay back until 9pm on multiple occasions. Despite the hours I was pulling at the hospital, I barely passed that OSCE.

This burden also has profound implications for our future careers. As identified by The National Medical Workforce Strategy scoping framework, student debt has been identified as a confounding factor of the maldistribution of doctors rurally and across certain specialties:

Graduates are older, with more debt. The increase in postgraduate medical schools and growing tuition and study costs mean that new graduates are older and have more debt.

These doctors have less career time to pay off their debts, which may influence their desire to enter highly remunerated subspecialties and their choice of practice location.

Considering these factors, it is worrying to see some medical schools take the approach of explicitly discouraging students from seeking part-time employment. Students are often told not to bother maintaining a job especially as they start clinical years. The reasoning behind this discouragement is completely valid – completing your clinical years requires many hours of learning at the hospital and the added stress of a job may burn you out. But for many medical students who rely on part-time work as their major income, they simply do not have a choice.

Medical schools who ignore the financial demands on medical students are only perpetuating finances as a barrier to studying medicine. Doing things like ensuring consistent clinical schedules that students can plan around, or offering free accommodation for rural placements, are first steps in reducing this barrier. As the medical profession looks at areas of inequity, I hope to see medical schools take financial inequity seriously so that medical students feel more supported to access income.

Research

WITH CHRIS JOHNSON

Balancing behaviour to fight obesity

A very active or physical job could mean that also getting too much rest runs the risk of obesity, according to new research from the University of South Australia.

Undertaken in partnership with Denmark's National Research Centre for the Working Environment, the University of Gävle, the University of Copenhagen and the University of Southern Denmark, the world-first study tracked the time-use behaviours of 807 blue-collar workers in bid to investigate links between work, leisure and obesity.

Classifying workers into four unique behaviour profiles– *'Ants', 'Koalas', 'Lions'* and '*Chimpanzees*' – based on their distinct behaviours both at work and at play, the team found that while being active is generally considered to be healthy, being very active at work but stationary at home, could have the opposite effect.

UniSA researcher, Dr Dot Dumuid said the findings contradict popular health messages.

"With the rise of obesity, public health messages rightly talk about being more active. But what they fail to convey is the importance of having a balance of active and restful activities across the day – both during work and leisure," Dr Dumuid said.

"Certainly, to prevent obesity, you need to exert energy, but looking at this in isolation is not showing us the full picture.

"Our research shows that '*Lions*' - people who spent much of their work time being active, but most of their leisure time sedentary or in bed – tended to have the highest risk factors for obesity.

"This is contrary to what you might expect, that people who are sedentary both at work and play – those we have dubbed '*Koalas*' – would be most at risk of obesity, when this is not the case."

Globally, obesity has reached epidemic proportions, with the World Health Organisation reporting more than 1.9 billion adults overweight, of which 650 million adults are obese. In Australia, more than a third of adults are overweight, with one in four being obese. The rapid growth of obesity is leading to increased risk of heart disease, type 2 diabetes and some cancers, costing the Australian economy billions of dollars each year.

The study recorded workers' movements over four 24-hour periods (including at least two working days), tracking data via a triaxial accelerometer attached to their thighs. Workers also completed a paper-based diary to note their activities. Obesity indicators included waist circumference, weight, and body fat percentage (BMI).

The study challenges the broadly held notion that a lot of activity is a good way to prevent obesity. Obtaining a balance of energy exertion is perhaps more important.

"An existing behavioural approach to prevent obesity is to exert more energy by increasing physical activity and reducing sedentary activity. However, this does not incorporate the recovery process – rest and sleep – which is also important for your body," Dr Dumuid said.

"If your body does not get enough time to recover, it can cause a state of chronic heightened inflammation which can induce adverse effects, such as storing excess energy as fat.

"Similarly, someone who is very active at work, but crashes in front of the TV each night is not getting the right balance either – the body needs a balance of activity and recovery throughout the day.

"With the rate of obesity continuing to grow, alternative approaches to obesity management and prevention are critical. We hope this research delivers new insights about how we can battle one of the world's most prevalent conditions."

Research

Antibiotic combination therapy study

New research from Monash University, in collaboration with the University of North Carolina, could change the way patients with life-threatening drug-resistant infections across the world are treated.

The research, led by PhD student Akosua Adom Agyeman and Dr Cornelia Landersdorfer at the Monash Institute of Pharmaceutical Sciences (MIPS), revealed that patients treated with antibiotic combination therapy were significantly less likely to die than those treated with a single antibiotic.

Drug-resistant infections already claim more than 700,000 lives every year. Without concerted action, a United Nations panel warns that resistant infections could kill 10 million people annually by 2050 and trigger an economic downturn that parallels the global financial crisis of 2008.

To prioritise global efforts, the World Health Organisation has identified the top three 'superbugs' that pose the greatest threat to human health. One of these is carbapenem-resistant Klebsiella pneumoniae (CRKP) that has become resistant to our most powerful antibiotics. In 2014 alone, CRKP caused more than 2.1 million serious infections worldwide, yet how patients suffering from these infections should be treated remains poorly understood.

The study, published in the *International Journal of Antimicrobial Agents*, evaluated the results of 54 studies involving more than 3,000 patients with CRKP infections from seven countries, and revealed that more than 37 per cent of patients died despite antibiotic treatment.

"These contemporary data reiterate the fact that we are running out of options in the treatment of infections caused by superbugs which are increasingly being encountered in routine clinical settings," Ms Agyeman said.

Globally, there are calls for new incentives to encourage antibiotic development. Despite this, many major pharmaceutical companies have backed out and the global antibiotic pipeline has stalled. Between 2000 and 2018, only 15 antibiotics were approved, compared to the 63 put to clinical use during 1980-2000. Only a handful of these new antibiotics belong to a new class targeting bacteria through novel mechanisms.

Equally concerning is that the time between the introduction of an antibiotic and the development of resistance has become increasingly shorter since 1970.

"We need better strategies to optimally dose our current antibiotics, as well as any new ones that become available, to suppress further resistance development and preserve their activity for the future," said Professor Chris Porter, Director of MIPS.

A promising strategy against drug-resistant superbugs is the use of antibiotic combinations – this study is the first meta-analysis on therapeutic outcomes of CRKP infections.

Choline vital for healthy diet

A recent roundtable conducted by the Australian Nutrition Advisory Council for Eggs has concluded that 90 per cent of Australians are not consuming the adequate intake amounts of choline in their diets.

Choline can be found in foods such as eggs, meat, fish and milk, as well as some green vegetables and wholegrains.

Food scientists and medical researchers recently convened to discuss Australia's current choline intake levels, the need for further research and elevating awareness of this important nutrient.

Many Australians are unaware of the benefits of choline and the need to incorporate foods containing the nutrient into their diet, despite it contributing to the development and function of all cells in the body.

Roundtable member Professor Tim Green of the South Australian Health & Medical Research Institute stated: "Research shows choline plays an important role in brain development and may help prevent birth defects during pregnancy and as well as reducing the risk of cognitive decline in older people.

"New research being conducted in the field has revealed that choline plays a much larger role in maintaining good health than originally thought."

Research

Diabetes case detection assessed

Blood glucose and HbA1c screening alone does not improve diabetes case detection and care for patients admitted to hospital from emergency departments, according to research published by the *Medical Journal of Australia*.

Researchers from hospitals and universities across New South Wales, set out to determine whether routine blood glucose assessment of patients admitted to hospital from emergency departments (EDs) resulted in higher rates of new diagnoses of diabetes and documentation of follow-up plans.

Blood glucose was measured in 133,837 patients admitted to 18 NSW public district and tertiary hospitals from an ED between May 31, 2011 and December 31, 2012, with outcomes followed up until March 31, 2016.

The hospitals were randomised into the intervention group and control group. Routine blood glucose assessment was done at both the control and intervention hospitals. In the intervention hospitals automatic requests for glycated haemoglobin (HbA1c) assessment and notification of diabetes services for patients with blood glucose levels of 14 mmol/L or more were undertaken.

The numbers of new diabetes diagnoses with documented follow-up plans for patients with blood glucose levels of 14 mmol/L or more were similar in the intervention (83/506 patients, 16 per cent) and control hospitals (73/278, 26 per cent), as were new diabetes diagnoses with or without plans (intervention, 157/506, 31 per cent; control, 86/278, 31 per cent). Thirty-day re-admission (31 per cent v 22 per cent) and post-hospital mortality rates (24 per cent v 22 per cent) were also similar for patients in intervention and control hospitals.

"Adding automatic requests for HbA1c assessment and notifying diabetes services at intervention hospitals did not lead to a higher proportion of patients receiving new diabetes diagnoses or plans for diabetes follow-up, nor did it significantly affect patient outcomes," wrote the authors, led by Professor N Wah Cheung, from the University of Sydney and a senior staff specialist at Westmead Hospital.

"Hospitalisation provides an opportunity for diagnosing previously unrecognised diabetes in patients. The incidence of new diabetes diagnoses in our study was comparable with that of older studies, in which 20–42 per cent of hospital patients with newly documented hyperglycaemia were further investigated or received an intervention.

"Our results suggest that routine blood glucose testing of patients admitted from EDs, an inexpensive intervention, can identify some patients with unrecognised diabetes.

"However, they also indicate that routinely requesting HbA1c assessment of ED patients, without well developed and adequately resourced plans for their management and referral, does not lead to increased diagnosis of diabetes or better hospital outcomes for admitted patients."

Step closer to malaria vaccine

Researchers have narrowed down the malaria proteins and disease-fighting antibodies that could be used to develop a vaccine against the most severe forms of malaria.

Malaria parasites grow within red blood cells, where they insert proteins (known as PfEMP1) into the surface. PfEMP1 proteins were collected from malaria strains from children in Papua New Guinea who had been naturally infected by the disease.

The research team managed to pinpoint which antibodies were most effective in fighting the most severe forms of malaria, by using antibody measurements from hundreds of different variants of the PfEMP1 proteins.

Deakin University's Associate Professor Alyssa Barry, who led the study, said the findings were a major step towards developing a viable vaccine for the disease.

Research

"As part of their survival strategy within the human host, malaria parasites use PfEMP1 to stick to the walls of blood vessels, and this can cause blockages to blood flow and inflammation, leading to severe disease," she said.

"Malaria parasites change these proteins to escape from developing immune responses, and every strain has a different set of proteins, making the identification of vaccine targets like finding a needle in a haystack."

There were 219 million cases of malaria worldwide in 2017, leading to an estimated 435,000 deaths, according to the latest figures from the World Health Organisation.

This research was a collaboration between Prof Barry, the Walter and Eliza Hall Institute of Medical Research (WEHI), James Cook University and malaria experts from PNG, France and the US.

"It's the first time anyone has shown this. For years, researchers have thought that developing a malaria vaccine based on PfEMP1 would be virtually impossible, because the proteins are just so diverse," Prof Barry said.

"It's similar to the flu vaccine, where you have to keep adjusting and updating it as the virus strains evolve from year to year. Malaria is even more diverse than influenza – one village in a country such as PNG could contain thousands of possible PfEMP1 variants.

"But in malaria-endemic areas, children who are repeatedly infected develop immunity to severe malaria by the time they're about two years old, so we know antimalarial immunity is possible, and it can develop after exposure to only a few strains."

Associate Professor Barry, who also heads the Translational Genomics Group at the Burnet Institute, said while immunity to milder forms of malaria presented a "formidable obstacle", immunity to severe malaria targets only a small subset of proteins that have many similarities between strains – making the essential components for a vaccine much easier to identify.

"Using genomic sequencing, we collected PfEMP1 proteins from different strains of malaria, measured antibodies to those proteins to identify the protective antibody – the biomarker of immunity – that protects kids against disease," she said.

"We were able to identify these antibodies by monitoring for patterns of disease, following the children in PNG for 16 months to determine which of them were susceptible to the more severe forms of the disease, and those who were protected and only experienced milder forms of the disease.

"It's been a long road, and has involved a large team, but it's a major step forward, and this provides hope that creating a vaccine might be possible."

The research paper *Protective immunity against severe malaria in children is associated with a limited repertoire of antibodies to conserved PfEMP1 variants*, was published in the *Cell Host & Microbe* scientific journal.

New project aiming to reduce suicides in pregnant women and new mums

A $100,000 research project will help build understanding of the factors contributing to suicide attempts in pregnant women and new mums. The research aims to develop effective ways to assess and manage suicidal risk in this vulnerable group.

Murdoch Children's Research Institute, James Cook University, and service provider and consumer advocacy group, Perinatal Anxiety & Depression Australia (PANDA) will collaborate on the study.

Suicide is the leading cause of maternal death in Australia during pregnancy and the 12 months following birth. This is despite the fact that women in this period have regular contact with care providers including midwives, GPs, obstetricians, and maternal health nurses.

Research

The first-of-its-kind study aims to explore and explain women's experiences of suicidality during pregnancy and the year following birth, a time known as the perinatal period, with the ultimate aims of:

- Understanding factors that may contribute to suicide at this time in women's lives;
- Identifying factors protective against suicidal behaviours; and
- Informing suicide prevention strategies for women during pregnancy and the year after birth

"In order to identify and introduce effective suicide prevention measures for expecting and new mums, we need to build a better understanding of this phenomenon," said the study's lead investigator, Dr Laura Biggs from the Murdoch Children's Research Institute.

"Very little is known about women's experiences of suicidality during pregnancy and the first year following birth. What we do know is that suicide is the leading cause of maternal death in Australia, and that women's suicidal behaviour has unique characteristics around this time.

"Given this uniqueness, we need to better understand factors that may contribute to and prevent suicide in the perinatal period. Our study aims to develop a model that explains suicidality during pregnancy and the year following birth. We can then use these findings to help us care for and support women and their families impacted by suicidality."

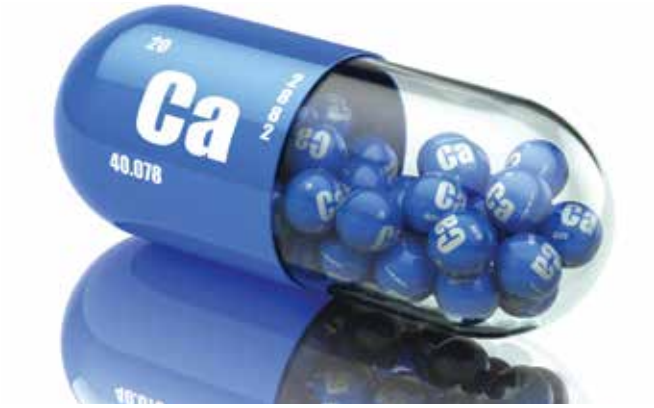
Professor Melanie Birks of James Cook University and co-investigator on the project, said the involvement of women with lived experience of suicidality during this potentially vulnerable time is crucial to the success of this project.

"The knowledge that is gained from this study will inform health professional education and practice, increasing the likelihood that suicidality in the perinatal period can be identified and effectively managed," Prof Birks said.

The research results will be directly translatable, changing clinical practice to improve outcomes for this at-risk group.

The 12-month project will begin recruiting participants in early 2020, with the results leading to larger scale studies and pilot interventions.

Calcium supplements are not modern medicine



Evidence suggests that calcium supplements have "very little place" in modern medical practice, according to the authors of a research review published by the *Medical Journal of Australia*.

Professor Ian Reid and Associate Professor Mark Bolland, both from the University of Auckland, reviewed the evidence of both efficacy and safety of calcium supplements, and vitamin D supplements.

"The use of calcium supplements in individuals without specific bone pathology does not have a sound evidence base, and the safety concerns suggest that the net effect could be negative," they wrote.

Calcium supplements are frequently associated with gastrointestinal symptoms, particularly constipation, and they have also been reported to double the risk of hospital admissions related to abdominal symptoms.

"In the Women's Health Initiative study, calcium and vitamin D increased the risk of renal calculi (kidney stones) by 17 per cent. There is evidence that calcium supplements increase the risk of myocardial infarction and, possibly, stroke, although this remains subject to controversy," they wrote.

Vitamin D supplements rarely cause symptomatic adverse effects, but there is evidence that vitamin D doses of 4000 IU/day, 60 000 IU/month, or 300 000–500 000 IU/year may increase the risk of falls and/or fractures. At lower levels -- doses of 400–1000 IU/day – bone benefits from vitamin D are met, therefore, the use of higher doses is not appropriate.

There are conditions for which calcium and vitamin D supplements are appropriate.

Research

"There are some medical conditions, such as osteomalacia, for which calcium and vitamin D supplements are central to management," the authors wrote.

"Their use as adjunctive therapy in osteoporosis has been the convention, but … there is little evidence that this alters outcomes.

"The use of supplements of vitamin D in patients at risk of vitamin D deficiency who need potent antiresorptives is appropriate. Calcium supplements in this context are currently accepted practice, and the safety and efficacy of romosozumab have not been demonstrated without them.

"Clinically significant vitamin D deficiency (ie, nadir 25(OH)D < 30 nmol/L) is common among individuals with minimal sunlight exposure, such as frail older people and those who are veiled, as well as in people from Africa, the Middle East and South Asia living at high latitudes.

"Supplementation of frail older people is widely advised, and also frequently provided for immigrant communities, particularly children, including those being breastfed.

"Vitamin D supplementation sufficient to raise 25(OH)D levels above 40–50 nmol/L is advisable; 400–800 units per day is usually adequate, unless there is some coexistent medical problem, such as malabsorption. Supplementation should be continued for as long as the cause of vitamin D deficiency (eg, low sunlight exposure) is present.

"Supplements have value in overtly deficient individuals, but not across the healthy older population. Based on the consistency of the data, we believe that a recommendation not to provide supplements routinely to healthy older individuals can be judged to be evidence-based … and no longer a matter of controversy.

"In summary, small doses of vitamin D have a place in the prevention of osteomalacia in individuals with specific risk factors. Calcium supplements have very little place in contemporary medical practice."

World News

WITH CHRIS JOHNSON

Serious measles outbreak in Samoa

Samoa is enduring one of the worst measles outbreaks in the Pacific island nation's history.

The Samoan Government has declared a State of Emergency and imposed restrictions on school attendances and other public movements and gatherings.

The number of people infected with the disease continues to grow, with at least 16 deaths confirmed and 1,174 cases recorded to date.

Most of the inflicted are babies and small children.

The Samoan Government has reached out to Australia for help.

Australia's Foreign Minister Marise Payne said that in response to a request from Samoa, Australia has provided support since November 4, which was 11 days before the State of Emergency was declared on November 15.

The Australian support includes a specialist team of doctors, nurses and public health experts, as well as urgently needed medical equipment and supplies.

"An Australian Medical Assistance Team (AUSMAT) will work alongside Samoan health personnel to provide urgent care to critically ill patients, support vaccinations and develop public health messages," Senator Payne said.

"The team has also established a portable eight-bed critical care unit to ensure the most vulnerable patients receive the care they need.

"AUSMAT is one of a few World Health Organisation (WHO) globally-verified Type-2 Emergency Medical Teams in the world, providing Australia with world-class capability to help our neighbours in times of need."

Australia is working closely with the Government of Samoa, WHO, the Government of New Zealand and other regional partners to coordinate response efforts and prevent the further spread of measles which, if not contained, could pose a risk to the region.

Australians travelling to Samoa, Tonga, Fiji and New Zealand are encouraged to make sure their vaccinations are up to date.

World News

Huge EU grant to help boost Palestinian-Israeli healthcare cooperation

Project Rozana, an international charity dedicated to building the health capacity of Palestinian society by leveraging Israel's world-class healthcare system has been awarded a €741,286 (A$1,193,650) grant by the European Union (EU).

The funds will expand the work of the Binational School of Psychotherapy (BNSP), a unique training program based at Hadassah Hospital in Jerusalem.

The BNSP was established in 2016 to train Palestinian and Israeli child psychologists in the latest strategies and techniques for dealing with children in the region suffering from post-traumatic stress disorder.

Project Rozana was founded in Australia in 2013. Today it has affiliates in Canada, Israel and the USA. Its mission is to build bridges to better understanding between Israelis and Palestinians through health.

The BNSP opened as a Project Rozana pilot program in 2016 with A$420,000 from World Vision Australia (WVA). The first cohort comprised eight Israelis and eight Palestinians (six from the West Bank and two from Gaza.

The success of the pilot and the resulting professional and personal outcomes encouraged Project Rozana to apply for funding under the EU Peacebuilding Initiative.

The announcement of the EU grant is a significant milestone for Project Rozana and seen as an endorsement of its approach to people-to-people relationship building. This also meets the EU's priority for professionalised programs that offer measurable outcomes and scalable models.

Tim Costello AO, the former CEO of WVA, said cross-border learning and cooperation between Israeli and Palestinian mental health professionals is critical to enhance psychosocial health care to children and adolescents.

"We have already noticed an increase in the professional interaction between Israeli and Palestinian mental health professionals as a result of their involvement in the BNSP," Mr Costello said.

"This is promoting co-existence and building mutual trust through shared experiences."

Mr Costello also said that the BNSP is contributing to women's empowerment by ensuring that no less than 50 per cent of students are women.

The EU grant represents 80 per cent of the funding needed for the next 40 months, with the balance to be provided by Project Rozana. It is estimated that the funding will allow for 60 Israeli and Palestinian psychotherapists working in the field of child and adolescent mental health to complete the course.

It will also fund the BNSP to undertake curriculum development and accreditation by the World Health Organisation.

Ron Finkel AM, founder of Project Rozana and Chair of Project Rozana International noted that since 1998, the EU has been actively supporting civil society initiatives in the Middle East.

"There is no shortage of worthy recipients, but through its EU Peacebuilding Initiative, they have chosen to make this grant to a relatively new organisation," he said.

"Even more impressive is that it represents 7.9 per cent of the total grant available in this funding round. I believe it's a deep endorsement of our work, our values and the importance of building cross-border professional networks."

World News

Bloomberg gets serious about ending youth vaping in the U.S.

In response to alarming levels of e-cigarette use among youth in the United States – including a 78 per cent increase among high school students in just one year – Bloomberg Philanthropies has announced the creation of a new $160 million initiative aimed at ending the youth e-cigarette epidemic.

The initiative, called Protect Kids: Fight Flavored E-Cigarettes, has goals that include banning all flavored e-cigarettes and stopping e-cigarette companies from marketing their products to children. The three-year program will be led by the Campaign for Tobacco-Free Kids, which will partner with other organisations including parent and community groups.

More than 3.6 million middle and high school students in the United States use e-cigarettes, accounting for about one-third of all U.S. e-cigarette users. E-cigarettes with kid-friendly flavors such as mint, mango, gummy bear and cotton candy are fueling this epidemic; 97 per cent of kids who use e-cigarettes use the flavored varieties, and 70 per cent report the flavors as the reason they use e-cigarettes.

Teen smoking rates in the United States declined by more than 70 per cent between 2000 and 2018, but the spike in e-cigarette use among youth threatens to undo a generation's worth of progress.

The creation of the initiative comes as health authorities in 33 States are investigating more than 450 cases of severe respiratory illnesses associated with vaping, with many cases involving teens and young adults.

"E-cigarette companies and the tobacco companies that back them are preying on America's youth," said Michael R. Bloomberg, Bloomberg Philanthropies Founder and World Health Organisation Global Ambassador for Noncommunicable Diseases.

"They are using the same marketing tactics that once lured kids to cigarettes, and the result is an epidemic that is spiraling out of control and putting kids in danger of addiction and serious health problems.

"The federal Government has the responsibility to protect children from harm, but it has failed – so the rest of us are taking action. I look forward to partnering with advocates in cities and States across the country on legislative actions that protect our kids' health. The decline in youth smoking is one of the great health victories of this century, and we can't allow tobacco companies to reverse that progress."

The initiative will support local advocacy efforts in cities and States including legislative and regulatory measures to remove flavored e-cigarettes from the marketplace. Researchers have identified more than 15,000 e-cigarette flavors available online.

The project will also ensure e-cigarette products are subjected to review before they reach the market and products now on the market are reviewed promptly. And it will seek to end marketing practices that appeal to kids, and stop online e-cigarette sales until sales to kids can be prevented

The silly season

BY DR CLIVE FRASER

It's that time of year again when children are on holidays and many doctors take a well-earned break from medicine.

It's nice to have the time to put your feet up, sit back and relax in front of the telly for a change.

But as everyone has noticed the decent offerings on free-to-air television are few and far between so most nights I'm now watching YouTube clips streamed to my flat screen.

And with Google having acquired YouTube in 2006, it's a service that uses algorithms to pick content for me based on my past Google searches.

So what do I like to watch when I'm not consulting?

For starters with 105,000 subscribers there's Gary Scott at Autoshine Cars.

A Scotsman based in Blackpool his YouTube clips start with "Hello boys and girls, it's me again", but after that his accent is incomprehensible.

The premise of his YouTube channel is that customers bring in their really dirty cars and in the next eight hours he details them back to as new.

Through the wonders of technology this is all compressed into a 15-minute video with a soundtrack of some of the best music I've ever heard.

A feature of his channel is that fast-forwarding through the cleaning makes the whole exercise appear to be quick, fun and entertaining.

I would say that his clips are mildly addictive (I watch them every night) and it is impossible to switch off until after the clean-car reveal.

His most-watched clip of cleaning a really dirty Mazda 6 has had 606,000 views and I'd suggest he makes more money from advertising and affiliate marketing than he does from cleaning cars.

Next there's Doug DeMuro with 3.2 million subscribers who takes viewers on a tour of "the interesting quirks and features" of all sorts of cars which are mostly garaged in Southern California (San Diego and Orange County).

His awkward and dorky style is accentuated by his appearance as he usually wears shorts and tee-shirts during his car reviews.

At over 1.9 metres tall he is built to test head and legroom.

He touches every button and then either pushes or pulls every knob before taking the car out on the road.

There is only ever one camera angle focussed on his beaming smile when he's driving and then he delivers a DougScore made up of weekend (enthusiast/fun) points and daily (practical/sensible) points.

Currently the car with the highest combined DougScore is the 1994 McLaren F1 with 74 points.

The lowest Doug Score belongs to the 1969 BMW Isetta with 25 points.

Hoovie's Garage has fewer subscribers at 810,000 but he makes up for it by buying the cheapest example of all sorts of mostly expensive older vehicles on their last legs.

Before YouTube Hoovie was a car salesman which is easy to see with his flash outfits and his capacious home with a garage the size of most hospitals.

His cars are neatly stacked vertically in the background of his videos, but every vehicle has expensive repairs pending after a trip to the local workshop manned by The Wizard who, wait for it, also has his own YouTube channel.

Car Wizard has a lot less subscribers, but his videos often have more views and are educational rather than entertaining.

But my favourite YouTube channel is Marty's Matchbox Makeovers.

Marty is based in Melbourne and each video is a nostalgic trip down memory lane for me as he restores the toys of my childhood to mint condition.

Please have a safe Christmas and I look forward to driving with you again in the New Year.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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AVIS: Experience superior service with Avis. AMA members receive a 10% discount when booking through www.ama.com.au

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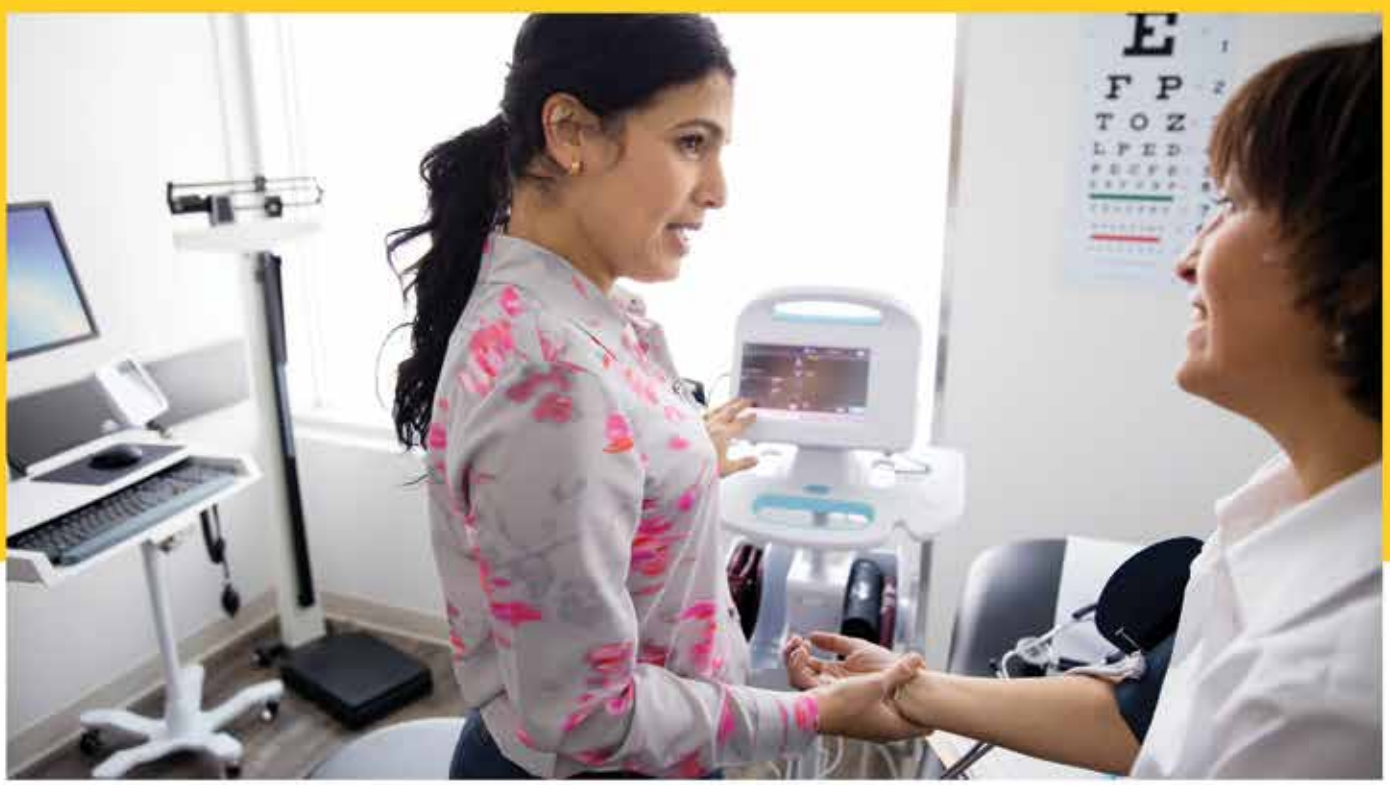
Post Nominals: AMA members can now use post nominal letters AMA(M). Terms and conditions apply.



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