

Planning for the future, learning from the past

This issue of the *MJA* covers figuratively and literally hot topics, with an underlying theme that learning from past experiences can only drive future improvements. For example, after decades of trials, three new Alzheimer disease medicines are undergoing an approval process in Australia, and patients, providers and the medical community need a plan on how to discuss the risks and benefits of their use if approved. Similarly, after decades of tracking the experiences of Australians, via Family Court disputes, Australia's largest longitudinal cohort study, or state health authorities' emergency department data collections, authors in this issue make contributions to several heated debates, including transgender care dispute resolution, out-of-pocket care costs, and planning for heatwaves.

With dementia affecting over 410 000 Australians in 2023 (www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/summary), of which 60–70% are estimated to be Alzheimer disease (www.who.int/news-room/fact-sheets/detail/dementia), the news that, after more than 30 years since the identification of amyloid- β proteins and approximately 300 failed Alzheimer disease therapies (www.nature.com/articles/s41392-023-01484-7), three new medicines may soon provide some (modest) benefit to individuals with this condition is important for patients and clinicians. In this issue of the *MJA*, Bhalala and colleagues (<https://doi.org/10.5694/mja2.52359>) present examples of how clinicians and care providers can articulate the effect of these medicines for patients and family members who will undoubtedly be asking about them. In their perspective article, the authors summarise the evidence of the three large novel monoclonal antibodies targeting amyloid- β trials, to a both a medical and lay audience, incorporating patient co-designed tools for information dissemination.

Dimopoulos and Taylor-Sands (<https://doi.org/10.5694/mja2.52345>) cover another emerging international topic. In their perspective, the authors introduce an alternative framework for resolving disputes between parents, clinicians and children regarding gender health care for transgender and gender diverse children that hopefully avoids court and legal involvement. Arising from the challenges raised by the *Re: Imogen* Family Court decision, which instituted the requirement of consent from both parents for puberty suppression or gender-affirming hormone treatment and a court application if any controversy arises between parents (www.mja.com.au/journal/2022/trans-youth-penalised-re-imogen-family-court-decision), the authors' recommendations are to keep legal involvement in disputes to a minimum. They suggest a focus on shared decision-making processes that are well supported by medicine. Their guiding principles for the proposed framework are reflective of best evidence-based and expert consensus-based medicine — including communication, autonomy, relationships and expertise (CARE). While the authors recognise the challenges of legislation of such framework, they call on the medical community to implement it in clinical treatment guidelines now.

Another noteworthy contribution in this issue, coming from the long-standing 45 and up Study, is presented by Goldsbury



and colleagues (<https://doi.org/10.5694/mja2.52367>). In an analysis of out-of-pocket costs of 45 061 participants with linked cancer records and long term follow-up, Goldsbury and colleagues reported that in the 7916 individuals who had cancer during the follow-up, those with cancer recently (less than two years) had a much higher likelihood of spending between >\$1000 (~42%) and >\$100 000 (~9%) in out-of-pocket health care costs. Although their costing estimates were blunt, ascertained from surveys, the differences in spending between patients with and without a recent cancer diagnosis were meaningful and varied by patient subgroups, including socio-economic status. In the accompanying editorial by Williams and Gibbs (<https://doi.org/10.5694/mja2.52365>), these differences in out-of-pocket costs observed are further explored, highlighting that health care-induced financial strain is still a concern in our universal, but often fragmented, health care system, as are inequalities, which should be further examined.

Finally, as we enter winter and forget the concerns of summers past, Thomson and colleagues (<https://doi.org/10.5694/mja2.52364>) remind us that heat health alerts, used by some state's health departments, are not enough to prevent the impact of heat on older people. Not only were older Victorian residents between 2010 and 2022 more likely to be admitted to hospital for heat-related issues during Victorian Department of Health's alerts, they were also more likely to be admitted to hospital for a range of other chronic conditions. With the upcoming 2024–25 summer expected to be one of the hottest ever on record (www.abc.net.au/news/2024-04-12/nsw-winter-forecast-one-of-warmest-on-record/103697742), this research letter serves as a reminder to prepare and continue to seek sustainable, innovative strategies to minimise potential harm. ■

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