REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION

RDMA's Newsletter

Newsletter
August 2022

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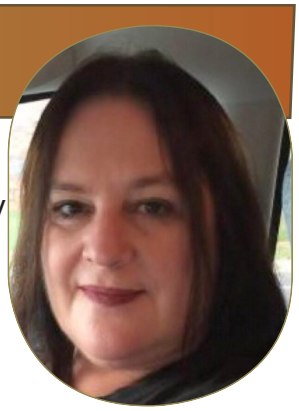
See Where We Work & Live P19. Overview of Vietnam War

RDMA's President Report Dr Kimberley Bondeson



We can welcome our new Federal AMA President, Dr Steve Robson, and the new Vice-President, Dr Danielle McMullen . Both the new President and Vice-President have hit the ground running and are working towards lobbying for a variety of issues for the medical profession. On the list includes hospital ramping, hospital patients waiting in tents in hospital grounds, and chronic wound care in general practice. There is also concerns about the decrease in doctors wanting to take up General Practice as a career, falling from 45% in previous years down to the current level of 15%, which is the lowest it has ever been. There is also marked frustration with the limited number of specialist training positions available across the board. Locally, we recently had our ASADA Senior Doctors conference at Mon Komo, which was a great success. There were a large number of interstate participants, and the outcome, as I see it, with the support of the AMAQ President and CEO is positive: What outcomes are these? To allow older GP's who want to work towards retirement, a step down category with reduced CPD to allow them to continue to contribute to the medical workforce and the medical profession.

Sounds simple, doesn't it. However, the current law will not allow this. How did this happen? In 2010, the national law was changed, so that there was a national registration for all doctors, which did away with each State Medical Council being responsible for the registration of doctors. The outcome of this change, as I see it, has had unintended consequences. And over the next few years, unless we do something about it, the problems that this change has created will continue to strangle the medical profession. We are already short of medical school teachers, and this will continue. In order to teach, under the current Australian system, you need to be a registered medical practitioner. In the past, prior to 2010, you did not need to be registered, and hence, many retired senior surgeons were the doctors who taught anatomy to medical students and registrars.

Present at the conference was a representative from APHRA, who confirmed that any doctor performing clinical duties which involved patient care, or making recommendations about patient care, needed to be a registered medical practitioner. There is a worldwide shortage of doctors, and this situation is going to get worse. In the UK, there are currently 100,000 positions vacant in the NHS currently being advertised. In Scotland, this number is 6,000 advertised vacancies. So, whereas in the past, Australia was able to rely on overseas doctors to prop up its workforce, this avenue is closing.

ASADA's goal is to see the development of an emergency action plan in Australia, to deal with earthquakes, tsunami's, floods, wildfires, and pandemic's, which currently do not exist. Australia relies heavily on the defence force to assist with these emergency situations. There is currently no civilian medical response, unlike other overseas countries, eg. UK, Canada and America, who have a medical reserve team that is well funded and organized. We await with interest to see how ASADA goes forward with its goal.

Continued Page 5

Note: Free RDMA Membership For Doctors in Training

RDMA Meeting Dates Page 2.

The Redcliffe & District Local Medical Association sincerely thanks QML Pathology for the distribution of the monthly newsletter.

RDMA 2022 MEETING DATES:

For all queries contact Angela our Meeting

Convener: Phone: (07) 3049 4444

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Next

Tuesday	February	22nd
Wednesday	March	30th
Tuesday	April	26th
Wednesday	May	25th
Tuesday	June	21st
Wednesday	July	27th
ANNUAL GENERAL MEETING AGM		
Tuesday	August	23rd
✓ Wednesday	September	28th
Tuesday	October	25th
NETWORKING MEETING		
Friday	November	18th

Newsletter Editor Dr Wayne Herdy

Newsletter Publisher.
M: 0408 714 984

Email:RDMAnews@gmail.com

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www.redcliffedoctorsmedicalassociation.org/

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INSIDE THIS ISSUE:

P 01: RDMA President's Report

P 02: Date Claimers and Executive Team Contacts

P 03: Contents and Classifieds

P 04:ASADA's National Conference - Update by ASADA President Dr Geoffrey Hawson

P 05: RDMA's Next Meeting Invitation

P 06 Do Too Much Screen Time? RDMA Vic President Dr Wayne Herdy

P 09 Research Giving Circle Donation and Symposium. Thank you to RDMA for Donation

P 10 AMAQ President and CEO Report

P 12 Vice President Wayne Herdy - Long Term Injectables

P 14 Laughter The Best Medicine - Dr Mal Mohanlal

P 15 USC Trials Clinical Trial of Investigational Vaccine for Cytomegalovirus CMV

P 16 Travel Article by Cherly Ryan

P 17 Poole Group Report

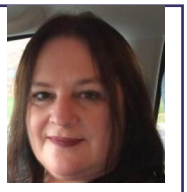
P 18: Media: Wounds a Costly Sore Point for the Health System

P 19: Where We Work and Live: An Overview of the Vietnam War

P 20: Members Subscription Form

RDMA Executive Contacts:

President:
Dr Kimberley Bondeson
Ph: 3284 9777



Vice President :
Dr Wayne Herdy
Ph: 5491 5666

Secretary:
Dr Geoff Hawson
Ph: 0418870140
Email: geoffrey@hawson.org

Treasurer:
Dr Peter Stephenson
Ph: 3886 6889

Committee Member:
Dr Alka Kothari
Ph: 3883 7777

Meetings' Conveners
Ph:3049 4444
Email: qml_rdma@qml.com.au
Ms Kym James &
Anna Woznaik
M: 0466480315

ASADA's National Conference - Update by ASADA President Dr Geoffrey Hawson

We had approximately 90 people who registered including 8 from interstate. People were very positive about the conference. There were 7 RDMA members who attended including Doctor Peter Marendy.

A report will make it in to the next edition of Wise Medicine for those who are ASADA members. There was a positive discussion with AMA Queensland as to how to progress the Step down registration category of Senior Active Doctor.

I had interviews with ABC Radio, Channel 9 and The Medical Republic which were published and the Courier Mail ran a piece on Saturday morning about the issues. The full program and bios of speakers (Stephanie Gallagher was unable to attend) is on the ASADA website (https://asada.asn.au) The current committee includes Geoff Hawson (president) Kimberley Bondeson (secretary) and Peter Stephenson were re-elected unopposed. A motion was passed to incorporate the association. Once this has happened there will be a fresh election for office bearers.

Representatives in the discussion of issues included the Medical Board of Queensland and Queensland AHPRA representatives, MDA National (MDO Rep) Prof Perry, Mr Stephen Milgate and Professor Alex Crandon. The ASADA Conference's special guests in attendance were AMAQ CEO, President Past President and Mr Stephen Milgate.

Ass Prof Geoffrey Hawson (UQ)
AMA Qld Council Senior Doctor Craft Group Representative
President ASADA https://asada.asn.au
Mobile: 0418870140

ASADA Audience

ASADA Conference AMAQ

ASADA Conference - Discussion on issues Medical Board, AHPRA and MDO

Next Meeting Date AGM 23th August 2022

Presenter Changed: **Dr Charana Perera, Watch them grow safely; a judicial use of psychotropics in pregnancy and women of child bearing age.**

Continued from Page 5

RDMA President Report

On another note, it was with interest I was reading the Science Advance article reported in Science Alert (August 2022) about the TB vaccination. This vaccine is targeted to protect again Myocbacterium tuberculosis and this vaccine has been found to offer a broad protection again a range of unrelated infections, including respiratory infections. This is also seen with the small pox vaccination, which is reported to give protection against monkey pox. Whilst this is not unexpected, it is good to see that there is now more documented cross-protection again various pathogens. This is also hopefully seen with the current Covid 19 vaccines. It will be interesting to see what occurs in the next month or so, which is traditionally our 'flu season'. Kimberley Bondeson

RDMA Meeting 27/07/22

Kimberley Bondeson introduced Nova Pharmacuiticals Representatives Sara Cook and Trisha Kerrin.

Speaker Dr Garry Deed.GPwSI,
Topic: Optimising Treatment of Obesity in Patients with Common Comorbidities lof Depression and Type 2 iabeties.

New Members: Thomas Clark, Heba Abdalla.

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 28th Sept 2022**

TIME: 7pm for 7:30pm start

VENUE: Regency Room – The Ox, 330 Oxley Avenue, Margate

COST: Financial members, interns, doctors in training and medical students – FREE. Non-Financial members – $30 payable at the door (Membership applications available).

AGENDA:

7:00pm	Arrival & Registration
7:30pm	Be seated – Entrée served Welcome by Dr Kimberley Bondeson – President RDMA Inc Sponsors: Bayer Australia Ltd Representatives: Brendan Greig, Kate Ziebell & Elmarie Heidstra
7:30pm	Speakers: Dr Himabindu Samardhi, Cardiologist Topic: Management of Atrial Fibrillation in 2022
8:00pm	Q&A
8:30pm	General Business - Dessert served Tea & Coffee served

RSVP: By Friday 23rd Sept 2022
(e) RDMA@qml.com.au or 0413 760 961

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RDMA VICE PRESIDENT'S REPORT
Dr Wayne Herdy

HOW MUCH SCREEN TIME?

My colleagues will recall that I have an addiction practice (well, maybe a third of my work is with addictions, but that's enough). Way back in the past century, I kept seeing occasional cases of kids with what is now recognized as gaming addiction (yes, it's in DSM-V). These kids would sit in front of their X-box (the fashionable driver of electronic gaming in their day), sometimes all day, not eating, not drinking, not going to the toilet. And their parents were powerless to stop their behaviour, attempts at discipline being met with tantrums and rages comparable to the antisocial violence of chemical drug addicts.

Addictions take many forms, not just chemical addictions. Shopping addiction, gambling addiction, even sex addiction. But gaming addiction has increased to a point where it rivals chemical addictions as a social evil. The version of this illness that causes me most personal distress is evident when I see Mums come into my consulting room, and hand the toddler a mobile phone to occupy the child's attention.

The child manages the device extraordinarily well, for an age group that does not yet understand letters or numbers. The child also controls the mother extraordinarily well, putting on a monumental tantrum if the device is removed, and the child has clearly taught that mother that only a dose of device time will allow her to manage a few minutes of her own life.

A few years ago, the World Health Organization started publicizing recommendations about safe or desirable levels of screen time. At first, the recommended time for under-2's was NIL. I regret that I do not think that I have any under-2's in my practice who enjoy NIL screen time.

Before COVID, a survey of American teenagers recorded that the average out-of-school screen time was a whopping 7.5 hours. How on earth can a teenager cram that much time into the gaps between school, meals, bathing, and sleep? Let alone having any time for what used to be recognized as developing normal social interaction. While the surveyors expressed incredulity at their findings, when they repeated the survey after two years of COVID, the figure had increased to an astronomical 8.9 hours per day. When do these kids find time to breathe?

I attended a conference recently which included a dissertation on the sequelae of screen time and screen violence. Part of the findings included MRI evidence of the brain activity of chronic gamers. Their frontal lobes – the chunks of the brain required to predict the outcomes of your behaviour, the source of normal social functioning – had become inactive and even physically reduced in size as well as activity.

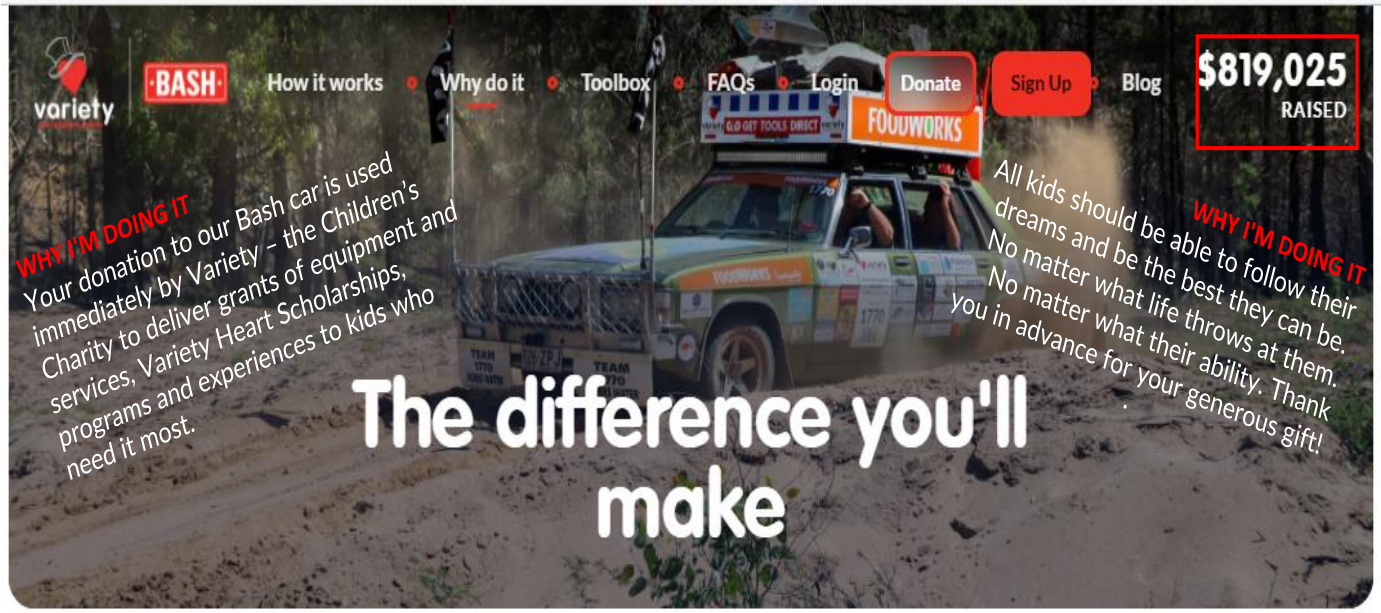
Teenagers are shrinking their frontal lobes by excess screen time. And that physical hardwiring change is presumably irreversible. When shown videos of violence, including quite horrific killings, the chronic gamers addicted to screen violence showed MRI changes equally disturbing. Their amygdala, the seat of emotions, actually shut down during the videos of extreme violence, including images of live humans being dismembered. I fear to speculate on what these gamers will end up doing in real life.

The message is clear. Parents need to become aware that mobile devices given to young children are not an innocent electronic babysitter, as we used to say in the early days of television. They inhibit the learning of the social behaviour, the concern for other fellow human beings, that are at the root of collective social functioning that has allowed homo sapiens to evolve above all the other creatures of the world.

(OK, I know that not everybody agrees with Richard Dawkins in "The Selfish Gene".) And there is now MRI evidence that they irreversibly alter the hardwiring of the immature brain. There are many hypotheses about why humans came to dominate the animal kingdom. If it is true that our sense of altruism and concern for our fellow man is the main reason for our success, then our electronic playthings are now threatening to drive us into extinction.

Wayne Herdy

Vice President RDMA



Winton to Yeppoon via Birdsville 29/8/22-7/09/2022

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To donate click this link and type in **Wayne Herdy and team** https://www.varietybashqld.com.au/t/wayne-herdys-team

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- Appropriate investigations
- Opportunities to reduce threat of pain via communication

PHYSIOTHERAPISTS: EDUCATION

- Empower and reduce catastrophizing
- Restore normal movement/posture
- Monitor & advise on exercise rehab program

EXERCISE PHYSIOLOGISTS: RE-INFORCE EDUCATION

- Help develop & implement graded exercise program
- Restore normal movement & posture with physiotherapist

OCCUPATIONAL THERAPISTS:

- Assist with aids/home setups/RTW plans
- Work closely with allied team to provide an effective pathway to functional outcomes

DIETITIAN:

- Reduce diet-induced pro-inflammatory state, weight management

PSYCHOLOGISTS:

- Tackle beliefs & address past trauma
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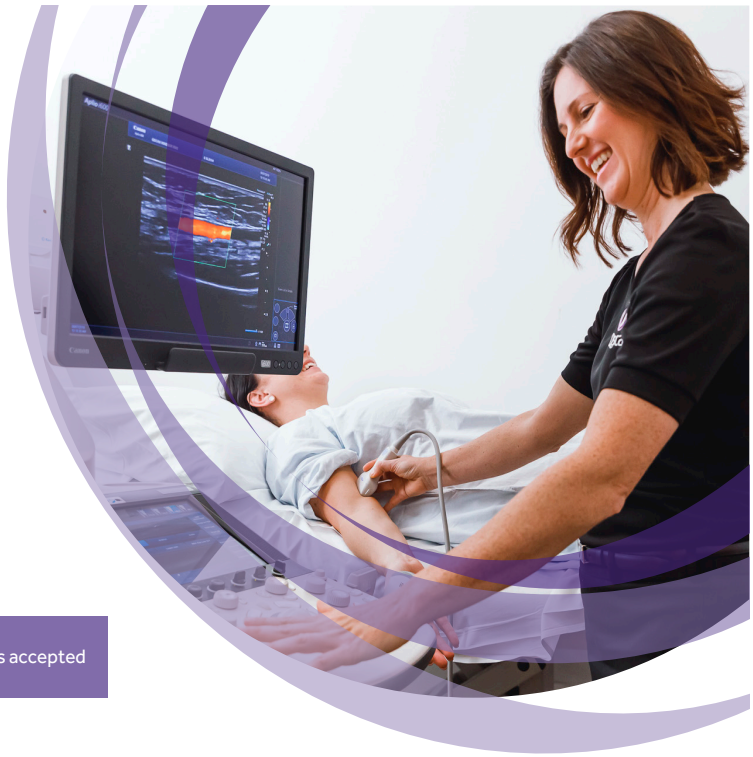

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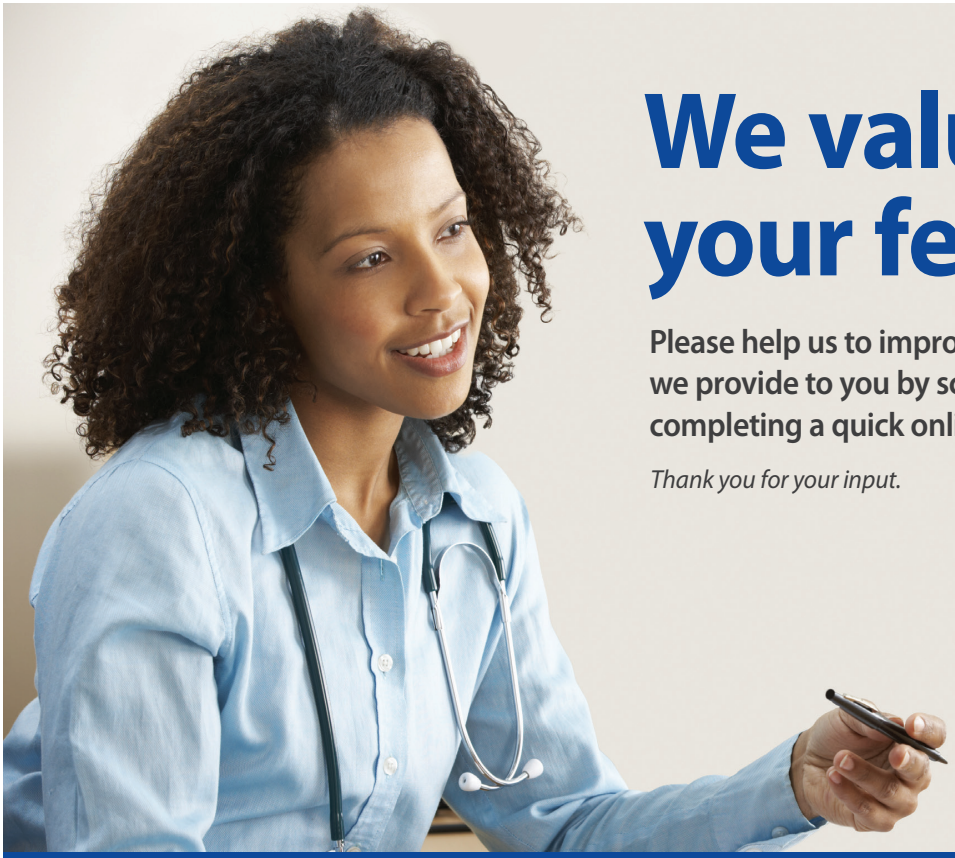

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Raise it for Redcliffe Hospital

Proudly supported by the RBWH Foundation

Thank You | Research Giving Circle Donation and Symposium

Dear Dr Bondeson, Dr Stephenson and the RDMA Executive and Members,

I wish to express my sincere gratitude for your donation as a **Raise it for Redcliffe Hospital 'Research Giving Circle' partner** through RBWH Foundation. You are helping to advance life-changing research at Redcliffe Hospital. Thank you! **You will find your tax-deductible receipt attached.**

Thank you for your commitment and vision – and that of the other Redcliffe and District Local Medical Association members. It is the passion and care of people like you who make the **Raise it for Redcliffe 'Research Giving Circle'** such a success. Your generous gift motivates others to give, and for that we are immensely grateful.

Already, Research Giving Circle Partners like you have helped Redcliffe Hospital to appoint the inaugural Senior Nursing Researcher, Associate Professor Amanda Fox. This significant role will advance high-quality research driven by local patient needs, in partnership with major universities and research institutes. That is one example of what you can help to make possible as a Research Giving Circle partner.

Your visionary Research Giving Circle gift will help take research to the next level by funding a major grant at Redcliffe Hospital. Such a grant may play a significant role in understanding patient needs, applying the latest technology, and finding better ways to deliver excellent patient care.

It has been wonderful to meet more of the RDMA Executive, too. Such a pleasure to meet you, Dr Stephenson, recently at The Golden Ox dinner with Associate Professor Alka Kothari! I have also attached a photo from the event – it was great to see the story in your recent RDMA newsletter.

Let me also extend an invitation on behalf of Dr Joel Dulhunty for the 2022 Redcliffe Hospital Research Symposium. If you would like to attend, I can arrange to send you an Outlook calendar invitation with the link embedded. It should be an inspiring online event and an opportunity to hear of the latest innovative research happening in our region.

Again, thank you for your invaluable support. Because of generous people like you, Redcliffe Hospital can continue research that leads to significant discoveries and improved patient outcomes in Queensland, across Australia and around the world.

You inspire us every day.

Sharyn Tidswell CFRE Fundraising Manager - Redcliffe Hospital
M: 0438 912 204
E S.Tidswell@rbwhfoundation.com.au

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PRESIDENT AND CEO REPORT

Dr Maria Boulton and Dr Brett Dale

Our hospitals continue to be overwhelmed with COVID cases, thousands of healthcare workers have been furloughed and, while the government pledged 2,500 new hospital beds in the state budget in June, most will not come online for years. We needed them yesterday.

We have also finally seen the official evaluation of the urinary tract infection (UTI) prescribing trial and the results are as bad as we feared. No follow-up was done with thousands of women who took part in this experiment, yet the government is pushing ahead to expand this to 23 conditions across North Queensland. The AMA has stepped up its advocacy against this dangerous experiment with patient health that will only make medical practice in regional Queensland harder.

COVID CRISIS CONTINUES

The Queensland Government says the winter COVID wave has peaked but we can expect new outbreaks every three to six months. We still have hundreds of COVID cases in hospitals and thousands of healthcare workers furloughed. Meanwhile, elective surgeries are being cancelled.

We continue to urge the Queensland Government to listen to medical advice. In the absence of mask mandates, we urge everyone to be sensible, take precautions and wear masks, because the strain in the hospital system affects us all. Read more: **qld.ama.com.au/news/COVIDforecast**

NORTH QUEENSLAND PHARMACY TRIAL

Drs Omar Khorshid and Maria Boulton

Dr Omar Khorshid used the last weeks of his federal AMA Presidency to travel to Queensland to step up our fight against the dangerous North Queensland pharmacy prescribing experiment.

Watch the video:
https://www.youtube.com/watch?v=CNKcSrBpFuc

The North Queensland pilot would allow pharmacists to diagnose, treat and prescribe and sell Schedule 4 medications for a range of conditions including asthma, diabetes, otitis media and chronic obstructive pulmonary disease, without any medical oversight and in breach of federal regulations.

Dr Khorshid met with local doctors in Cairns and visited Yarrabah Aboriginal Community. It's one of the communities targeted for this pilot despite having a highly successful collaborative healthcare clinic with its own pharmacist.

He was horrified to learn that neither the Premier nor the Health Minister have visited Yarrabah to ask the community if they wanted this trial. In Brisbane the following day he challenged state politicians to

consult with North Queensland communities about the healthcare systems that work for people, not political donors.

The North Queensland experiment is based on the alleged success of the urinary tract infection (UTI) prescribing trial – yet the government's own evaluation of this trial revealed 270 cases of complications but a follow-up rate of only 35.7 per cent of the trial participants, with 3,000 women unable to be contacted.

Read more about our campaign: **qld.ama.com.au/Stop-NQ-Pharmacy-Trial**

NEW FEDERAL PRESIDENT

Drs Maria Boulton, Steve Robson and Grea Duncombe

AMA Queensland President Dr Maria Boulton was in Sydney for the AMA National Conference, where Dr Steve Robson and Dr Danielle McMullen were elected new national President and Vice President. Dr Boulton talked to ABC Radio Sunshine Coast about NatCon.

Read a transcript of her reflections: **qld.ama.com.au/news/NatCon**

TELEHEALTH CHANGES

The AMA is continuing to lobby for the reintroduction of telehealth rebates that ended on 30 June 2022.

While we welcome the new federal government's decision to create a telehealth items for COVID anti-viral management, we still need to see the rebates for longer phone consults reinstated. Read more about the AMA's actions: **qld.ama.com.au/news/Telehealth**

RESIDENT HOSPITAL HEALTH CHECK

Our seventh annual survey of doctors in training has opened and we encourage all junior doctors to share their experiences at Queensland hospitals. The collated survey results are critical for understanding where hospitals are doing well and where there's room for improvement, to ensure we support the growth of our medical workforce.

The survey is run by AMA Queensland and our Committee of Doctors in Training in collaboration with ASMOFQ, Queensland's doctors' union. It's open until midnight Monday 22 August. Read more: **qld.ama.com.au/news/RHHC2022**

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RDMA VICE PRESIDENT'S REPORT
Dr Wayne Herdy

LONG-ACTING INJECTABLES

I have been managing drug addicts for about 30 years now.

In the early days, our only viable option was Opioid Substitution Treatment (OST) with methadone. We were trading off a life of irregular supplies of white powders of uncertain composition and uncertain purity and unknown dosage for a life of a regular supply of a known dose of a known substance with known purity. The addicts were still addicts, but they were controlled. More or less. And all the nasty behaviour that went with drug addiction, the social evils of crime and prostitution and poverty, the sharing of blood-borne viruses, the medical end-stages of addiction with heart valve disease, hepatic failure, metastatic infections, all were reduced to some extent. More or less.

The mantra was harm minimization. We did not eliminate harm, but we made the world a safer place, for the patients and for the public at large. At a cost – expended health resources and endless battles over the perceived "entitlement" to takeaway doses, the biggest single factor creating conflict between patients and prescribers (and their ever-suffering reception staff). Addiction practitioners would ruefully admit among ourselves that the greatest benefit of our work was crime reduction.

Along came the next miracle drug, buprenorphine. As an agonist-antagonist, it had a lot of advantages over methadone. Buprenorphine (Subutex) is more than simple OST, it is not just replacing an illicit drug with a legal one. Still a narcotic (and well known as TemGesic, a remarkably low dose of sublingual buprenorphine offering very effective post-operative analgesia), it latches on the mu receptors (and a few others) and tells the patient that they have an opiate on board and didn't need to go hunting daily for any more. We now have more or less reasonable control of the addict, but better than methadone. With methadone, the confirmed addict would occasionally shoot up something off the streets, and top up their methadone fix.

By binding the receptor sites tightly, buprenorphine also blocks other narcotics. The addict established on buprenorphine might occasionally try for another hit of their preferred poison, but finds it ineffective. Well, that was a waste of time and money, wasn't it? And combine buprenoprphine with naloxone, we get an even better product (Suboxone). Naloxone doesn't do much if swallowed or administered sublingually, but if the dose is diverted and injected intravenously, the addict goes into instant withdrawal. Nasty, we won't do that again.

Addiction practitioners prescribing "subbies" have a much easier time than they do with patients on methadone, much fewer difficulties with takeaways and telephone disputes with pharmacies.

Methadone patients get quite obsessed with tiny changes in their doses, but buprenorphine patients are far more tractable and negotiable. But there is still a lot of finesse and skill in negotiating the pathways to control with buprenorphine patients.

However, there is a light at the end of the tunnel. Addicts who insist that methadone is the only drug that works for them are telling me that they have every intent of using extra illicit drugs at whim.

Patients who choose (or agree to) buprenorphine often have a real desire to get off all drugs and rehabilitate themselves into social normality.

RDMA VICE PRESIDENT'S REPORT
Dr Wayne Herdy Continued from Page 12

LONG-ACTING INJECTABLES

Along comes the next evolution in narcotic addiction treatment, the long-acting injectables. Essentially, the two products on the market in Australia are depot injections of buprenorphine. It is not appropriate here for me to discuss the pros and cons of the two brands, Sublocade and Buvidal, but I have a clear preference for one.

The change from a daily dose of buprenorphine to a monthly injection does not at first blush sound like such a significant variation, but my experience is that it represents a tectonic change in management. For perspective, of my 180-something addict patients, over 100 are now on LAI's. My patients have changed from daily dosing of something, often dosing at the pharmacy for every dose, and after months of stability enjoying the privilege of a few precious takeaways.

They now present at my practice once every four weeks. Instead of having serum levels up and down every 24 hours, they have stable serum levels, declining ever so slowly over 3 or 4 months. No withdrawal effects.

I cannot overemphasize the difference between daily dosing and monthly dosing for an addict. I have had patients present a week or two late for their monthly injection, saying "I forgot".

Dwell on that for a moment – I have patient who for the past 30 years has woken every morning with just one thought on his mind, where to get his next fix. Even on the Suboxone program, they had to take a dose every day, often at a designated dosing point populated by so many other addicts. Dosing was a daily reinforcement of the "I am an addict" mentality and a frequent reinforcement of their ongoing contact with the drug-using subculture.

A few months on the new regime, and they have forgotten that they are/were an addict??? Not one or two of my 100-plus LAI patients, but a few dozen – have taken the biggest step ever in their lives towards social normality.

For what it is worth, my life as a prescriber is so much easier. With a depot injection, we have no arguments or negotiations about takeaway doses, they just don't exist. Can you imagine the Nobel prizes to be won if we were to invent a monthly injection that allows diabetics to forget that they were diabetic? (Or asthmatics or hypertensives, or choose your chronic disease.)

With the advent of the long-acting injectables, addiction practitioners now have a real chance of transforming narcotic addicts into worthwhile citizens.

And the product is so easy to use, and turns the patients into much nicer humans, that I entertain a fond hope that a few of my colleagues who have declined to mange addicts in their practices might now be prepared to unburden me of some of my workload.

A small footnote. This discussion has all been about narcotic addiction.

The rapidly growing cohort of addicts who are essentially unmanageable by anything like the regimes described herein, are the ice addicts.

Sorry, I don't have an answer to that one yet.

Wayne Herdy

Laughter- The Best Medicine

I must agree when they say laughter is the best medicine. Here is a joke I came across in Quora, which I think our readers will enjoy. I do not know who wrote it, but it reflects a keen insight into human behaviour. – Mal Mohanlal

A lady goes to her parish priest

A lady goes to her parish priest one day and tells him, "Father, I have a problem. I have two female parrots, but they only know how to say one thing."

"What do they say?" the priest inquired.

"They say, 'Hi, we're prostitutes. Do you want to have some fun?'" the woman said embarrassingly.

"That's obscene!" the priest exclaimed, "I can see why you are embarrassed."

He thought a minute and then said, "You know, I may have a solution to this problem. I have two male parrots whom I have taught to pray and read the Bible. Bring your two parrots over to my house, and we will put them in the cage with Francis and Job. My parrots can teach your parrots to praise and worship. I'm sure your parrots will stop saying that...that phrase in no time."

"Thank you," the lady responded, "this may very well be the solution."

The next day, she brought her female parrots to the priest's house.

As he ushered her in, she saw his two male parrots were inside their cage, holding their rosary beads and praying.

Impressed, she walked over and placed her parrots in with them.

After just a couple of seconds, the female parrots exclaimed out in unison, "Hi, we're prostitutes. Do you want to have some fun?"

There was a stunned silence.

Finally, one male parrot looked over at the other male parrot and said, "Put the beads away, Francis; our prayers have been answered!"

USC AUSTRALIA | Clinical TRIALS

Clinical trial of an investigational vaccine for cytomegalovirus (CMV)

We are looking for females who are:

- between 16 and 40 years old
- in good general health
- in close contact with at least one child aged 5 or under, if aged 20 years or older
- are not pregnant, or planning to become pregnant within the next 9 months

There will be additional screening criteria discussed over the phone with research coordinators.
The study will involve three intramuscular injections of the investigational vaccine spaced between two to three months apart.

Eligible participants will be compensated for their time on study. This study will not affect your eligibility for a COVID-19 vaccination; however we ask that you confirm any planned COVID-19 vaccination dates with us first as there are some timing.

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Brisbane
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52 Merivale Street
South Brisbane QLD 4101
07 5409 8630

Sunshine Coast Haematology & Oncology Clinic
10 King Street
Buderim QLD 4556
(07) 5479 0000

Antarctica

By

Cheryl Ryan

The coldest and the largest wilderness area on Earth, Antarctica is embraced by high mountain ranges, myriad exotic wildlife and evergreen landscapes which are topped with ice beauty. Tourists from all over the ball come to explore the white continent every year.

The frozen land is filled with breath-taking scenic views and appeals to travellers with the chance to explore one of the most untouched areas of the globe.

Adventure is the very idea of an Antarctic vacation because it is obvious people don't visit this place to enjoy sunburns. Because of the extremities of this landmass, not many people have explored this place so it simply means you will have a phenomenal experience that is not known to many.

Camp under the Antarctic twilight

Camping under the twilight sky and dozing off on the coolest sleepovers is not everyone's cup of coffee but if you are enthusiastic and willing to give on the luxuries for a night then this experience will be on your mind forever.

The Hovgaard island on the west side of the peninsula offers one such campground and you must catch up with this spot by evening to admire the transition it will offer. It is truly a surreal experience and knowing there is nothing in between you and the frozen glory is a mystic feeling.

Hop on a zodiac boat

Antarctica is all about going to those spots where your cruise won't. Hop on a compact inflatable boat designed especially for travellers ready to buzz between the icebergs and around the peaks.

You will relish moving parallel to the breath-taking scenes around the sheets and the high-rises. Don't get intimidated when a fur seal or baby penguin pops around you to say hi.

Explore a research zone

If you are a science enthusiast, then you have landed in the right place. The white continent is a site for some of the most edge-cutting exploration centres which enthral tourists all over to take a trip around these intriguing facilities.

Verandsky Research Centre offers you a stop while making research on glaciology, meteorology, ecology, and physics.

What we have planned for you

- Take a walk around the peninsula to speculate on a colony of the emperor penguin.
- Take a polar plunge fully submerging in the icy waters.
- Rent a helicopter to witness the jaw-dropping blood falls.
- Visit the Trinity church to heal your soul.

This place is way more than snow and sheets, come and it will offer you an experience worth taking!

FBT EXEMPTION FOR ELECTRIC CARS INTRODUCED TO PARLIAMENT

The Bill amends the FBTAA 1986 to exempt from fringe benefits tax cars that are zero or low emissions vehicles held by the provider and used by or made available for private use of employees. Additionally, to be eligible for the exemption the value of the car at the first retail sale must be below the luxury car tax threshold for fuel efficient cars. This is to encourage a greater take up of electric cars by Australian road users to reduce Australia's carbon emissions from the transport sector, by making electric cars more affordable. The operation of the amendment will be reviewed after three years in light of electric car take up.

When the Bill becomes law, the FBT exemption will apply retrospectively from 1 July 2022 to eligible electric cars that are first held and used on or after 1 July 2022. An electric car ordered prior to 1 July 2022, but not delivered until after 1 July 2022, will still be eligible for the exemption. This will apply even if an employer acquired the legal title to the car before 1 July 2022. Second-hand electric cars may also qualify for the FBT exemption, provided the car was first purchased new on or after 1 July 2022.

New FBT exemption for Electric Cars

The FBT exemption relates to car fringe benefits and therefore will only apply to vehicles that are 'cars' for FBT purposes; other types of electric vehicles are excluded. Additionally, to be eligible for the exemption the value of the car at the first retail sale must be below the luxury car tax threshold for fuel efficient cars.

Generally, a car fringe benefit arises where a car is applied to or made available for private use to an employee, or an associate of an employee, by their employer.

Car benefit is exempt

Under the proposed amendments, a car benefit will be exempt if all the following conditions are satisfied:

- The benefit is provided to a current employee
- The car is a 'zero or low emissions vehicle'
- The value of the car at the first retail sale (i.e. purchase price) was below $84,916 for 2022-23, which is the luxury car tax threshold for fuel efficient cars
- The car was first held and used on or after 1 July 2022.

The benefit exempted from FBT is the private use of the vehicle, including any associated costs of running and maintaining the car for the period the car fringe benefit was provided.

Eligible Electric Cars

This amendment will apply to cars that are:

- Battery electric vehicles
- Hydrogen fuel cell electric vehicles; and
- Plug-in hybrid electric vehicles

Collectively referred to as zero or low emission vehicles. This will pose some tax planning opportunities for employers that make vehicles available to their employees.

Dale Trickett, The Poole Group

Australian Medical Association Limited
42 Macquarie Street, Barton ACT 2600:
PO Box 6090, Kingston ACT 2604
ABN 37 008 426 793
T: (02) 6270 5400 F (02) 6270 5499
Website : http://www.ama.com.au/
AMA

WOUNDS A COSTLY SORE POINT FOR THE HEALTH SYSTEM

A new report from the AMA shows the crippling cost of medical dressings and treating chronic wounds could be mitigated through targeted investment which would save the health system $203.4 million over the next four years. The report — Solutions to the chronic wound problem in Australia — says chronic wound care is a poorly understood and under-funded public health issue, despite studies indicating chronic wounds affect 450,000 Australians and cost $3 billion each year.

The AMA is calling on the Commonwealth to provide more support for GPs to provide high quality wound care for patients through the establishment of a national scheme to fund medical dressings for chronic wounds and extra Medicare funding to cover the unmet costs of providing care for patients suffering chronic wounds.

AMA modelling shows chronic wounds treated in hospitals place an additional burden on an already stretched system, with the AMA's modelling indicating they resulted in close to 32,000 hospital admissions in 2019–20 costing $352 million and 249,346 patient days. The report provides costed solutions to improve wound management in general practice and estimated savings associated with the proposed MBS items.

AMA Vice President Dr Danielle McMullen said the AMA's analysis shows investing $23.4 million over four years to deliver best practice wound care for diabetic foot ulcers, arterial leg ulcers, and venous leg ulcers would save the health system $203.4 million. "This is a no brainer for a government desperate to cut the deficit. I don't know of many investments where for every $1.00 you spend, the return is $8.36, but this is the case with evidence-based wound care."

Dr McMullen said the plan would also improve access to GPs, with research showing additional Medicare funding for wound care would free up around 148,000 general practitioner consultations in the first year, and 162,000 consultations by the fourth year, making an enormous difference to patients.
"As GPs, we see some terrible consequences for patients if a wound isn't managed properly, like amputations at the worst and nasty infections at least. They can take months or even years to heal and these are totally avoidable. "At the moment Medicare doesn't cover the cost of the dressings we need to treat chronic wounds correctly, so doctors are either bearing the costs themselves or are forced to pass on the cost to patients, and that's not something we like doing."There is a lack of awareness about the significance of chronic wounds in Australia, which means vulnerable patients, mostly older Australians, Aboriginal and Torres Strait Islander peoples, or patients with other chronic conditions, often suffer in silence and fall through the cracks in our health system. "The government often mentions its inherited trillion-dollar debt, so it should be looking for smart investments which will save the health system money and deliver better health outcomes for patients at the same time," Dr McMullen said.

The AMA's five-point solution
A Commonwealth-funded wound consumables scheme to subsidise the cost of dressings and other consumables provided in general practice for patients with chronic wounds.
The implementation of a stepped model of care for the management of chronic wounds, with improved access to other healthcare professionals involved in wound care such as podiatrists and dieticians, to form GP-led healthcare teams.

Three new Medicare items to facilitate the stepped model of care, including a Medicare item to allow trained practices nurses, Aboriginal and Torres Strait Islander Health Practitioners or Aboriginal Health Workers to provide short-term treatment.
Implementation of a national education and training program on the prevention and management of chronic wounds, with access to the consumables scheme and extra Medicare support linked to completion of this education and training.
Improved coordination of wound care initiatives in the sector under a national program to reduce duplication of effort.

CONTACT: AMA Media: +61 427 209 753 media@ama.com.au
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Where We Work and Live

Vietnam War 1962–75 | Australian War Memorial (awm.gov.au)

Vietnam War 1962–75

By late 1970 Australia had also begun to wind down its military effort in Vietnam.

The 8th Battalion departed in November (and was not replaced), but, to make up for the decrease in troop numbers, the Team's strength was increased and its efforts became concentrated in Phuoc Tuy province.

The withdrawal of troops and all air units continued throughout 1971 – the last battalion left Nui Dat on 7 November, while a handful of advisers belonging to the Team remained in Vietnam the following year.

Accession Number: P01404.028
Phuoc Tuy province, South Vietnam, November 1966: 6RAR soldiers follow an armoured personnel carrier (APC) during Operation Ingham, a "search and destroy" mission.

In December 1972 they became the last Australian troops to come home, with their unit having seen continuous service in South Vietnam for ten and a half years.

Accession Number: CUN/66/0161/VN
Vietnam, 1966: Australians patrol near the village of Tan Phu, near Bien Hoa Air Base.

Australia's participation in the war was formally declared at an end when the Governor-General issued a proclamation on 11 January 1973. The only combat troops remaining in Vietnam were a platoon guarding the Australian embassy in Saigon (this was withdrawn in June 1973).

In early 1975 the communists launched a major offensive in the north of South Vietnam, resulting in the fall of Saigon on 30 April. During April a RAAF detachment of 7–8 Hercules transports flew humanitarian missions to aid civilian refugees displaced by the fighting and carried out the evacuation of Vietnamese orphans (Operation Babylift), before finally taking out embassy staff on 25 April.

From the time of the arrival of the first members of the Team in 1962 almost 60,000 Australians, including ground troops and air force and navy personnel, served in Vietnam; 521 died as a result of the war and over 3,000 were wounded.

The war was the cause of the greatest social and political dissent in Australia since the conscription referendums of the First World War.

Many draft resisters, conscientious objectors, and protesters were fined or gaoled, while some soldiers met a hostile reception on their return home.

The End

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