RDMA

RDMA & NLMA's Joint Newsletter

Newsletter

AUGUST 2017

RATS OF TOBRUK: Continued

See Where We Work & Live on page 20.

http://anzacportal.dva.gov.au/sites/default/files/rats-of-tobruk-transcript

President's Report Dr Kimberley Bondeson

We are still having beautiful cold nights and bright sunny days. Winter is still with us. And the flu season has arrived early this year and with a vengeance. It is an early flu season, with reports that it is the worse one in a decade. We are seeing influenza A and B, and adult RSV, as well as adenovirus, all of which are not covered in the current influenza formulation vaccination.

And the EKKA is here, which is traditionally followed by the most influenza cases of the season – so this flu season is expected to continue into August and September.

Macquarie University, which is home of Australia's newest full-fee paying medical school, is going to graduate an extra 60 doctors – 40 domestic, and 20 international. The Macquarie MD program, will take in 60 full-fee paying students from 2018. The full course fee for domestic students will be $256,000 over four years. The medical school will be complemented by additional training spots at Macquarie University Hospital, which Macquarie University owns and operates. The medical school would be offering extended clinical placements in a hospital in Hyderabad, India, as part of the medical degree.

Workforce projections show an expected surplus of 7000 doctors already by 2030. There are seven medical schools already in NSW. There are 4 medical schools in Queensland. The major problem that we are already seeing is a lack of intern places, as well as training places, Australia wide.

The Healthcare Homes care trial project is still being pushed by the Federal Government, with a special contract being designed by the Federal Government for IPN, the country's largest GP corporate practice. The scheme will see practices get monthly capitation funds from the Department of Health to pay for the chronic disease care of patients. What this means is uncertain, as there are varying reports of 24 IPN practices joining, and then 20 IPN practices pulling out at the last moment due to concerns that the funding model, would trigger a massive new payroll tax burden. I will continue to watch this space with interest.

Dr Herdy's Variety Bash is to come, called 2017 The Surf & Turf Variety Bash. He has a new/old car (they need to be over 30 years old), and from the photos we saw and the description of the trip that Dr Herdy gave us last year, this venture will be as good, if not better!. A fantastic way to donate to a worthwhile charity. And then we get to see to see the pictures.

Kimberley Bondeson,
RDMA President

RDMA & NLMA's Joint Newsletter

Welcome from

Dr Robert (Bob) Brown

President Northside Local Medical Association

Note: Doctors in Training RDMA Membership is Free

RDMA Meeting Dates Page 2.

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Partnering with Redcliffe & District Local Medical Association for more than 30 years.

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

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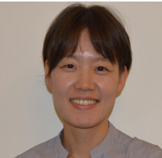

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Advertising information is on RDMA's website
www.redcliffedoctorsmedicalassociation.org/

RDMA 2017 MEETING DATES:

For all queries contact Anna Wozniak
Meeting Convener: Phone: (07) 3049 4444

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe
Time: 7.00 pm for 7.30 pm

Wednesday	February	22th
Tuesday	March	28th
Wednesday	April	26th
Wednesday	May	24th
Tuesday	June	27th
Tuesday	July	25th
ANNUAL GENERAL MEETING - AGM		
Wednesday	August	23th
Tuesday	September	12th
Wednesday	October	25th
NETWORKING MEETING		
Friday	December	1st

RDMA NEWSLETTER DEADLINE

Advertising & Contribution 15 July 2017
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W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants
Time: 6.45 pm for 7.15 pm

1	February	14th
2	April	11th
3	June	13th
ANNUAL GENERAL MEETING - AGM		
4	August	8th
5	October	10th
6	December	12th

Next Meeting Date 23rd August 2017

RDMA Meeting for 25.07.17

Dr Kimberley Bondeson, RDMA President Introduced the Sponsor Genesis CancerCare Queensland Representative Fiona Humphreys with Beverley Blakeway who in turn ntroduced the Speaker for the night: Dr David Schlect, Radiation Oncologist whose Topic was Radiation Therapy for Skin Cancer

Below: 1. Dr David Schlect Speaker

Clockwise: 2. Beverley Blakeley with Wayne Herdy RDMA Vice President.

3. Drs David Schlect and Geoff Hawson,

4. Topic for the night by Dr Schlect.

5. Dr David Schlect & Fiona Humphreys.

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 23rd August**

TIME: 7pm for 7:30pm

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
7:35pm	Sponsor: Iconcore
7:40pm	Speaker: Dr Jason Restall Clinical Haematologist/ Haematopathologist Topic: Bruising in the Community Patient
8:15pm	Main Meal, Question Time
8:40pm	General Business, Dessert, Tea & Coffee
8:45pm	Annual General Meeting

RSVP: By Friday 18th of August 2017
(e) RDMA@qml.com.au or 0466 480 315

Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology PUB/MR/1330, version 1 (Jan-16)

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Its Here Again 30 Aug-8 Sep, 2017 The Surf & Turf Variety Bash

SUPPORT A WORTHWHILE CHARITY,
Variety The Childrens Fund
Variety supports disadvantaged & sick children and their families.

Dr Wayne Herdy is again an entrant for this year's Bash starting soon!!

GET YOUR TAX DEDUCTION:
DONATE at the new website link:
https://https://www.variety.org.au/bash/bashers/car-5555/

The team behind your result

QML Pathology has spent more than 90 years servicing Queensland and northern New South Wales medical practitioners and patients.

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AMAQ BRANCH COUNCILLOR REPORT
DR KIMBERLEY BONDESON, GREATER BRISBANE AREA

THIS SEASON'S INFLUENZA OUTBREAK, NATIONAL DISABILITY INSURANCE SCHEME (NDIS),SAME SEX MARRIAGE & AMA FEDERAL NATIONAL CONFERENCE

The public and private hospitals are both struggling with the influx of influenza.

Recently, one of my patients with full private health ended up in the Redcliffe Hospital short stay unit overnight, and there was absolutely no private hospital beds anywhere on the northside for her.

Interestingly, the TV doctors are still stating that this season's flu vaccination is covering the influenza outbreak we are seeing, but there is no way it is.

Many of my patients, who had the flu vaccination, are still coming down with either influenza A or B, confirmed on culture.

An increase in the Medicare levy from 2% to 2.5% (of total income) in 2019 has been introduced recently into Federal Parliament, to help fund the $22 billion National Disability Insurance Scheme (NDIS).

Official data has revealed that 2540 NDIS participants have been granted at least $100,000 a year in funding, and 391 have packages worth more than $200,000 a year.

The NDIS does not cover medical costs already paid through medical or housing costs.

Has an unsustainable nightmare been created?

Only time will tell. It expects to be fully operational and supporting 460,000 people by 2019.

Australia is shortly about to embark on a postal survey on same-sex marriage.

Interestingly, US research has shown that marriage equality legislation is associated with a reduced number of suicide attempts in adolescents.

A study published in the medical journal JAMA, compared suicide attempts across public schools in the 32 states that allowed same-sex marriage, before and after the laws were implemented.

Those states that allowed same-sex marriage had a 7 per cent reduction in the proportion of high school students reporting a suicide attempt. (The Australian, 18/8/17 page 15).

Shortly, I am on my way to the annual AMAQ Conference held in Rome next month.

This year's topic is "Personalised Health Care - Evolving Health Care Needs through the Cycle of Life".

It features international and Australian guest speakers, including our Northside LMA President, Dr Bob Brown and his wife, Carmel Brown.

I look forward to reporting back on what is normally an extremely interesting and informative conference.

I

Sincerely

Kimberley Bondeson

August 2017

AMAQ Councillors Report

Branch Councillor – Greater Brisbane Area

AMA QUEENSLAND'S ANNUAL CONFERENCE

ROME

17 - 23 SEPTEMBER 2017

PERSONALISED HEALTH CARE – EVOLVING HEALTH CARE NEEDS THROUGH THE CYCLE OF LIFE

Doctors, practice managers, registered nurses and other medical industry professionals from around Australia are invited to attend the *Annual AMA Queensland Conference* in Rome.

The program will feature high-profile European and Australian speakers on a range of medical leadership and clinical topics. RACGP points will be on offer.

To find out more about the conference program or to register, please contact:

Neil Mackintosh, Conference Organiser
P: (07) 3872 2222 or
E: n.mackintosh@amaq.com.au

Download a conference brochure from the events calendar at www.amaq.com.au

Interesting Tidbits NATTY MOMENTS:

When a Man Takes a Wife Continued:

My wife and I were happy for twenty years. Then we met.

ALEC BALDWIN

A good wife always forgives her husband when she's wrong.

BARACK OBAMA

Marriage is the only war where one sleeps with the enemy.

TOMMY LEE

A man inserted an 'ad' in the classifieds: "Wife wanted". Next day he received a hundred letters. They all said the same thing: "You can have mine."

BRAD PITT

First Guy (proudly): "My wife's an angel!" Second Guy: "You're lucky, mine's still alive."

JIMMY KIMMEL

"Honey, what happened to 'ladies first'?" Husband replies, "That's the reason why the world's a mess today, because a lady went first!"

DAVID LETTERMAN

"First there's the promise ring, then the engagement ring, then the wedding ring... Soon after....comes Suffer...ing!

JAY LENO

By all means marry. If you get a good wife, you'll be happy. If you get a bad one, you'll become a philosopher.

SOCRATES

RDMA EXECUTIVE & AMAQ COUNCIL MEMBER RETIRED DOCTOR REPRESENTATIVE

Dr Geoff Hawson

Letter in Response to Retirement or Change in Scope of Practice by Dr Chris McLaren

We owe a debt to Geoff Hawson for taking on the role of Retired Doctor Representative on the AMAQ Council, and his recent informative REDAMA article. "Retirement" has many connotations but is defined in the Oxford Dictionary as "the action or fact of leaving one's job and ceasing to work". Is this really about what we senior doctors are all talking? There are clearly some doctors who are able to walk away from their profession of many years without regret. Then there is the majority of us, less well adjusted to life outside medicine, who prefer to change their "scope of practice", perhaps in a gradual fashion over some years. However we will all eventually have to face the strict definition of "retirement" because nothing will foreseeably alter our inevitable and inexorable decline in intellectual function over time. This can occur prematurely (eg. neurological disease or substance abuse), or it is simply due to the loss of neuronal function which accompanies the ageing process. In all of us there will come a point in time when we will be unable to reliably and competently provide the high standard of any form of medical care to which our patients have become accustomed and the Legislators and Courts demand. To go out with one's "boots on" is not an option.

For doctors who are members of Avant I would recommend viewing their Webinar "Hanging Up Your Stethoscope". It addresses the issue of age-related intellectual function and the bad news is that human "flexible intelligence" declines inexorably, irrespective of measurement method, from age 30 and falls below the total population mean after the age 45 of. What saves us is "crystallized intelligence" (wisdom of age) which rises with age and remains stable into the 7th decade (Salthouse TA. When Does Age-Related Cognitive Decline Begin? Neurobiol Aging. 2009; April: 30 (4): 507-514). Insurance companies are keenly aware of life risks and were the first to recognise that hypertension and smoking caused premature death. For these companies increased risk (in this case professional litigation) is a financial penalty to the company and this risk is necessarily reflected in the level of premium paid. So how do we, our indemnity insurers and society decide when the risks of continuing practice are too high and the licence to practice medicine should be handed back or withdrawn? It is all about risk management because there is no such thing as "no risk" in medical practice. A doctor in their 40's, presumably at the height of their knowledge base and intellectual powers, can still be successfully sued for malpractice. Risk management sounds like an indemnity insurance issue and it may be that insurance companies will step in, because of financial imperatives, and make certain professional hurdles a prerequisite to obtaining indemnity insurance. This would probably be an improvement on the current unscientific and facile "tick a box" assessment made by the Medical Board of Australia. If a doctor is currently non-specifically involved in using one's medical skills (eg. full time laboratory research), satisfies a CPD programme (sleeps through lectures) and maintains medical indemnity insurance (just in case the first two criteria don't weed out those unfit to practice) then public safety is assumed to have been assured.

The difficulty is that there is no "one size fits all" given the broad diversity of medical practice and individual variability of intellectual change. Basic laboratory research, medical administration, general clinicians, pathologists, radiologists, academics and highly specialised subspecialists are all incorporated into the broad church of medical practice. Our profession relies heavily on personal ethics limiting our individual scope of practice- eg. an insightful doctor, using good clinical judgement, would not suddenly begin to perform complex surgical procedures in the back room of the surgery with instruments not properly sterilised. This goes to the heart of our profession- the patient's welfare is central to our decision-making and supersedes our own egos and those of the regulators. This relies on possessing insight and displaying good judgement in patient -related matters. Unfortunately these personal skills will decline with age and when most needed they may fail us and result in harm to the very patients we are trying to protect. Should we wait for the proverbial "tap on the shoulder"? This is a flawed methodology because our junior colleagues would be reluctant to "tap" a senior colleague, or even if we are "tapped" we may lack sufficient insight to be aware of it. But by the time one is "tapped" it is too late as damage to patients has already become apparent to

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Letter in Response to Retirement or Change in Scope of Practice by Dr Chris McLaren

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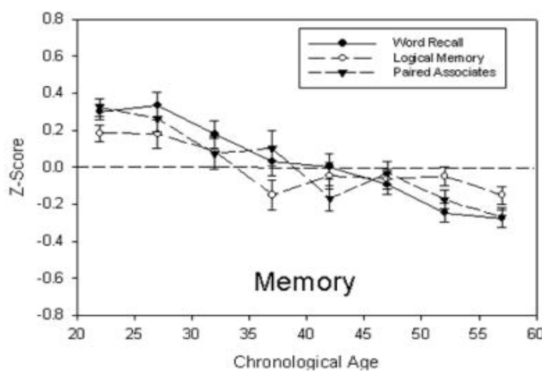
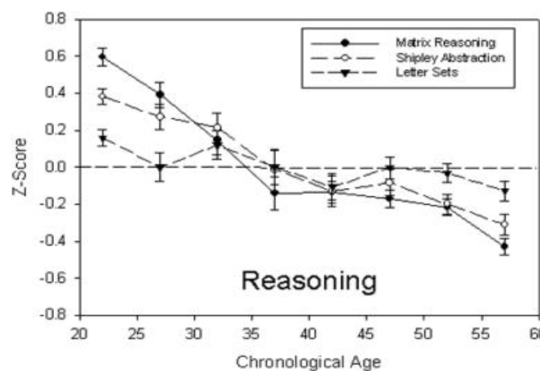
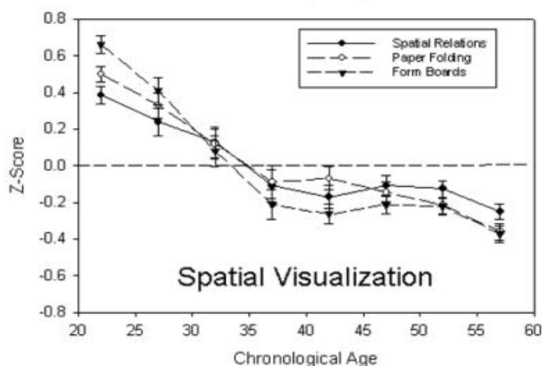
others.

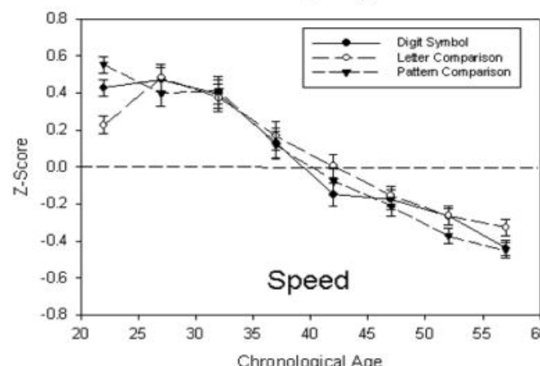
The scenarios discussed above are extreme and the reality is that most doctors use insight and judgement to scale down their scope of practice, often over some years, before deciding to completely retire. No damage is done to patients over and above what would be normally expected from the vagaries of medical practice. Under the current registration requirements there comes a point in this process (eg. 150 hours of work rather than 152 hours of work during a registration cycle) when we no longer are technically able to be registered. This loss of registration results in the inability to perform even the most rudimentary of medical functions such as writing prescriptions, ordering tests and writing referrals. This is particularly difficult for experienced clinicians who see their not so clinical colleagues still able to perform these functions. Is this the fault of the doctor who has lost the skills of insight and judgement or is it the fault of the regulator which has failed to appreciate that the doctor still possesses the necessary knowledge base and qualities to continue to function within their scope of practice? These skills and wisdom are then completely lost to society unlike other professionals (eg. Judges) who can be called out of retirement to preside over Royal Commissions and Government Enquiries which can have a major impact on Australian citizens' lives. What is their recency of practice and CPD status?

The vexed question is "Could there be a better way whereby the public is protected from truly substandard doctors and those doctors who are not substandard can continue, if they wish, to make a contribution to society despite being in the semi-retirement and retirement phases of their lives?" If there is a way who or what should lead it?









Reference: Salthouse TA. When Does Age-Related Cognative Decline Begin? Neurobiol Aging. 2009; April: 30(4):507-514.

Legislators and Medical Boards have produced the tragedies of Bundaberg Hospital and more recently Mandatory Reporting. Innocent people have died or suffered serious injury as a direct result of these "reforms".

Universities are suffering budgetary restraints and are more focussed on making money than innovating to produce a quality product, as well as having had governance issues of their own, particularly in Queensland.

Our Medical Indemnity Insurers certainly have a financial stake in the overall process of medical registration and scope of practice and would be able to bring some statistical methodology, derived from claims data, to the debate. The Medical Board of Australia would also be able to contribute similar statistical data from its complaints process. Avant already knows (watch the Webinar) that a spike in claims against an individual doctor is often a signal of intellectual deterioration. Unfortunately by relying on these processes means that patients have already been injured. Our Medical Colleges are largely responsible for CPD programmes (under APHRA supervision), a prerequisite of registration. Our Colleges should **Continued on Page 9**

Letter in Response to Retirement or Change in Scope of Practice by Dr Chris McLaren

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be aware of our scope of practice and the necessary knowledge base for this should be reflected in our CPD activities. What is missing is an assessment of a doctor's ability to bring all this together, when faced with a patient, and being able to display appropriate insight and judgement in patient assessment and management, the final distillation products of our training, knowledge base and intellectual skills. Broad definitions of "Practice" and "Recency of Practice" are the current surrogates used by the Medical Board of Australia in order to assess these skills. Using these criteria means that complaints have to be made before anyone (Medical Board, Indemnity Insurer) is aware of a doctor's potential unfitness to practice. Of course a complaint does not necessarily mean that a doctor is unfit to practice illustrating the complexity and difficulty of this assessment method.

I don't claim to have a scientifically based answer to this issue of medical registration but no one else seems to have one either. The current blunt instruments used by regulators are unproven and have caused harm. Revalidation, as a prerequisite to medical registration, is a reality overseas and is undergoing serious debate in Australia. Resitting final year undergraduate and College entry examinations have been thankfully ruled out. There is a focus on incorporating revalidation into College CPD programmes and encouragingly an evidence based approach is favoured (Medical Board of Australia Newsletter, Feb 2017). My suggestion, based on forty-two years of clinical practice but no other hard science, is to incorporate a test of clinical insight and judgement, appropriate for one's scope of practice and knowledge base, into the CPD programmes and forming a part of the revalidation process. It should be applied irrespective of the doctor's age, type of practice or recency of practice. If a doctor can continue to demonstrate good clinical judgement, for their scope of practice, and have an appropriate knowledge base as assessed by being actively involved in a CPD programme, there is no reason why a doctor whose scope of practice is limited to writing prescriptions, ordering tests and writing referrals cannot continue to do so. After a lifetime of practicing medicine surely our capacity to sit down and elicit a relevant history from a patient does not need to be tested if we can pass the above tests.

How might such a registration process be implemented and monitored to the satisfaction of the Australian public (Legislators and Boards) and the medical profession? The Medical Colleges already are very experienced at overseeing CPD programmes and understand Scope of Practice. If they are to be involved in revalidation then they are the obvious instruments of supervision. A measurement of a doctor's insight and clinical judgement could potentially be carried out by a case-based questionnaire with correct answers relating to the individual doctor's scope of practice. The same case would have different correct answers. This would not be a test of knowledge (this is part of the CPD programme) but more a test of one's ability to assimilate patient data, understand the meaning of the data and formulate a sensible approach to managing the clinical scenario presented relative to the doctor's scope of practice. Essentially a test of combined flexible and crystallised intelligence would be more reliable. Being able to "look things up" would be a necessary part of this process. Knowing when one should look up factual information and where to look are fundamental qualities of a doctor exhibiting insight and sound clinical judgement. Age should not be a barrier to undergoing such a registration assessment as significant cognitive impairment can occur at any age, although demonstrably becomes more common in the older age groups. Perhaps more frequent assessments in these age groups would be appropriate similar to what occurs when applying for a driver's licence renewal. Of course monitoring outcomes would be an essential part of implementing any new system and the obvious measures would be complaints made to the Medical Board of Australia and our Indemnity Insurers.

The above are just the "musings" of a "senior" medical practitioner forced to think about these very issues for personal reasons. Our profession needs to take the lead on the "retirement" issue (which means different things to different doctors) and provide guidance to our Legislators and Regulators.

The issue will be whether or not they have sufficient flexible and crystallised intelligence to listen to our voices from the coalface and take advice. I

f history is any guide they probably don't but that should not deter us from trying. Our patients are depending on us and we are depending upon Geoff Hawson to represent us.

Chris McLaran.

The Betrayal of Retired Doctors

by DR MAL MOHANLAL

Letter in Response to Dr Geoff Hawson's Topic

I must congratulate Dr Geoff Hawson on his excellent article (July 2017, RDMA Newsletter) on retiring doctors and wish him well in his effort to bring a common sense approach to a matter that affects all doctors, sooner or later.

He brings the point home that under the present laws once a doctor retires he becomes totally redundant. That is he cannot practice medicine again.

However, I am afraid his goose has already been cooked by none other than his own colleagues in the Royal Colleges and the AMA.

They have voluntarily put their heads in the government's noose by agreeing to administer quality control in medicine which of course is a political con job.

Now of course the government can tighten the noose any time it wishes and the rank and file members of the profession have no say in the matter.

You see the government is all about politics, giving the public the perception that they are doing everything and the public is being protected by having all these measures implemented.

By co-operating with the government in these measures the medical profession is also trying to give the public the impression that we are practising high standard of medicine.

But are we? I have always believed this to be a con and now it has backfired on us.

We all know that medicine is an inexact science. The measures we take to practice high standard of medicine can never be guaranteed.

One can be certified perfectly fit and healthy one minute, yet the next minute that person can drop dead.

Yet the government and the medical profession are involved in distorting and creating this perception among the public that this is not the case.
Who is trying to con whom?

Clearly our myopic medical leaders are suffering from a disorder of perception.

They have to question what role they wish to play in society because the role they play has a direct effect on their thinking process.

In my mind at present they are playing the role of Porky Pig selling pork chops and sausages on behalf of the government.

This role is really no good for anyone's mental health and for the medical profession it is untenable.

Clearly the CPD with its points system is a con job. We have put ourselves in this straitjacket, not the government.

From the number of complaints AHPRA receives each year, one can see that it has no bearing on the standard of medicine we practice. In fact it just reflects fake standards as a show piece for the public.

If doctors want to be independent like the legal profession, it should be scrapped. It should not be tied to medical registration.

It is juvenile, unscientific and regressive.

It is like making a kid write a hundred lines saying 'I must not talk in the classroom' and think that you have knocked some sense into him.

Who is kidding whom?

All the time I thought the medical profession was full of smart, OP1 grade individuals.

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The Betrayal of Retired Doctors

by Dr Mal Mohanlal (continued from page 10)

Letter in Response to Dr Geoff Hawson's Topic

However after looking at the legal profession and the way they look after their own interest and how their retired judges can be recalled anytime for active duty, I can only say that we are pretty stupid and dumb to put ourselves in this position.

The only way we can reverse this process and improve our mental health at the same time is to change our perceptions and admit to the public and the government that medicine is not an exact science.

We have to tell the public that there can be no guarantees in medicine.

The healing power lies within every individual, not outside him or her and this lies in the person's immune system.

Healing always takes place within the individual, not outside him or her. We have to be honest and tell the public that doctors do not 'cure' anything.

What we do as doctors is provide the right conditions so that we can help the person's own immune system to heal him or herself.

If the person's immune system collapses or does not respond, no doctor in the world can save that person.

This is the only way we can help an individual to take care of him or herself and become responsible for his own health.

It is the only way of improving the mental health in society.

How would you view the present situation if all of us doctors were in a prison camp, and if the authorities appointed the Royal Colleges and the AMA as chief cooks to run the prison kitchen?

Would you trust these guys to plan an escape to lead us out of the prison camp?

It is time for our medical leaders to review this untenable fraudulent role they are playing of protecting our interest and at the same time trading away our rights to practice medicine after we retire.

If they do not become honest with the public as indicated above, I can only foresee a grimmer future for the medical profession.

We are already a laughing stock among the politically aware individuals.

The legal profession for one must be rolling over in stitches seeing their medical colleagues with their brilliant minds out manoeuvring each other to turn their hard earned precious medical degrees into a worthless piece of 'sh..'.

Or should I use the word 'sheet'?

Yes your medical degree is not worth the piece of paper it is printed on, once you retire.

Now do you still believe that we are very clever and our medical leaders are doing a great job protecting our interest?

Don't you feel a sense of betrayal here after a life time of service to the community?

Clearly this demeaning of the retired doctor is an indictment on the combined leadership of our profession.

Politics is not the game doctors should be playing, if we wish to retain our sanity.

Mal Mohanlal

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Dr Jason Restall
Clinical Haematologist

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Radiation Treatment for Non Melanomatous Skin Cancers (NMSC)

Skin cancer is the most common malignancy in our society and makes up about one third of cancers diagnosed resulting in over 400,000 cases being diagnosed in Australia each year. Non melanomatous skin cancer (NMSC) is predominately comprised of basal cell carcinomas (BCC) and squamous cell carcinoma (SCC) which make up two thirds and one third respectively. Cure rates for NMSC are high with less than 1% cancer deaths occurring from NMSC.

Radiation treatment (RT) has been used for skin cancer for more than 50 years and it remains an important modality of treatment in selected cases. It may be used as definitive treatment or as an adjuvant therapy for high risk lesions after surgical excision.

The primary goal of treatment in NMSC is to cure the patient and a secondary goal is to provide the best cosmetic and functional result with minimum impact on quality of life. In deciding what modality of treatment to use, clinicians will need to take into account the site of the tumour, stage, histology and high risk features, comorbidities as well as the patient preferences. Radiation therapy provides an excellent balance between cure and cosmesis.

Superficial therapy (SRT) produces low energy X-rays to treat superficial skin cancers up to 8mm in depth. The effectiveness of SRT for SCCs and BCCs is high with a 5 year local control of 95% which is comparable to many surgical series.

A new modality of SRT is electronic brachytherapy (EBT). This involves the placement of a high dose rate X-ray source directly in a skin applicator close to the skin surface, and therefore combines the benefits of brachytherapy with those of low energy X-ray radiotherapy. The Esteya EBT system is specifically designed for skin surface brachytherapy procedures. These devices deliver surface brachytherapy without radioactive isotopes or linear accelerators, eliminating needs for extensive shielding. This type of treatment is only suitable for lesions less than 2cm in size and less than 3mm in depth.

For more advanced lesions, electron or photon therapy is available. RT may be used as definitive treatment in low-risk cancers or may be used as an adjuvant treatment in high-risk disease. RT provides a safe and effective alternative to surgery in selected cases and is particularly useful in the elderly, or where surgery would impact on function or cosmesis.

A comprehensive portfolio of RT techniques are available through the ROC network at the North Lakes centre, phone 3453 0000 for information.

The Medical Journal of Australia • MJA
MEDIA RELEASE

ACTIVE CASE FINDING, NOT SCREENING FOR COELIAC DISEASE

ACTIVE case finding in high risk groups is an appropriate way to diagnose, treat and manage coeliac disease, according the authors of a Narrative Review published in the *Medical Journal of Australia*.

The most recent estimated prevalence of coeliac disease in Australians is 1.2% in adult men (1 in 86) and 1.9% in adult women (1 in 52). It is an immune-mediated systemic condition triggered by exposure to gluten in the diet. If left undiagnosed and untreated, coeliac disease may lead to nutritional deficiency and there is a small long term risk of gastrointestinal malignancy.

“In the largest mortality study to date, the proportion of deaths from malignancy (30.4%) was higher than in the general population (23.6%), and was the second most common cause of death in patients with coeliac disease after cardiovascular disease,” wrote the authors, led by Professor Marjorie Walker, professor of Anatomical Pathology at the University of Newcastle, NSW.

The argument for active case finding is compelling:

“Recent studies show that children with diabetes mellitus type 1 and Down syndrome have a high prevalence of coeliac disease, which may present with abdominal pain and constipation rather than classical diarrhoea — also pointing to case finding in this group,” the authors wrote. “Although current evidence is not sufficient to support mass screening for coeliac disease, active case finding is very appropriate in high risk groups.”

Diagnosis is made via:

- serological tests — blood tests that look for certain marker antibodies — that must be conducted when the patient is still eating gluten in their diet, otherwise, any test will not be accurate;
- human leucocyte antigen (HLA) testing — looking for particular genetic markers found in 99% patients with coeliac disease; and
- biopsy — while there are visual clues to the presence of coeliac disease, visible at endoscopy, a biopsy will confirms the diagnosis by histology.

The treatment for coeliac disease is a gluten free diet, “which requires substantial patient education, motivation, access to a dietitian and follow-up,” according to the authors.

Regular follow-up is crucial, wrote Professor Walker and her co-authors:

“The National Institute for Health and Clinical Excellence guidelines recommend offering patients an annual review, to include symptoms review, weight and height measurements and dietary assessment to consider the need for specialist dietetic and nutritional advice,”.

“Follow-up should also include bone density measurements after one year of a gluten free diet in patients with additional risk factors for osteoporosis or who are aged 55 years or over. A gluten free diet is a core management strategy for osteoporosis prevention.”

Healing from coeliac disease may take “considerable” time, the authors wrote.

“Mucosal healing in coeliac disease takes a considerable time: studies show that this can take up to 2 years in children and up to 8 years in adults. A recent Australian study showed that adherence to a gluten free diet improves both mucosal healing (85% of patients showed improvement and 53% showed remission) and consequences of nutritional deficiency at 5 years.”

Please remember to credit the *MJA* — this assures your audience it is from a reputable source

The *Medical Journal of Australia* is a publication of the Australian Medical Association.

The statements or opinions that are expressed in the MJA reflect the views of the authors and do not represent the official policy of the AMA or the MJA unless that is so stated.

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AMA

AMA BACKS TGA ON CODEINE

The AMA today reiterated its support for the Therapeutic Goods Administration (TGA) decision to make codeine a 'prescription only' medicine from 1 February 2018.

AMA President, Dr Michael Gannon, said today that the AMA fully supports the independence of the TGA in making decisions about medicines scheduling, including for codeine.

"There is compelling evidence to support the decision to make codeine prescription only," Dr Gannon said.

"Deaths and illness from codeine use have increased in Australia.

"This is despite a rescheduling decision in 2010 shifting many over-the-counter codeine medicines to Schedule 3, which is 'pharmacist only'.

"There is no evidence that low-dose codeine provides any benefit beyond placebo.

"Patients who have short term pain will still have access to alternative over-the-counter painkillers, which are more effective than low-dose codeine, but without codeine-associated risks.

"It is better for patients with chronic pain to manage it with doctors' advice on appropriate medicines and non-medicine treatments, rather than self-treating with codeine for the long term.

"Codeine is not a safe treatment for long term or chronic pain."

Dr Gannon said the TGA has effectively communicated its codeine decision with the health sector and with the general public, and has actively sought feedback from the medical and health communities, including pharmacists, through participation in its working groups.

"The decision has been made - what we need to see now is cooperative implementation," Dr Gannon said.

"The AMA urges all stakeholders to not deviate from the TGA decision, which was made with open and transparent consultation.

"At this stage, we do not want to see the peddling of alternative models, dressed up as 'patient concern', which undermine the TGA position.

"We are extremely concerned at recent reports of some groups endeavouring to influence or coerce State governments to change, delay, or dilute the impact of the TGA decision.

"This is not in a patient's best interest. It goes against the decision made by the independent regulator.

"We already know that pharmacist control of codeine use does not work.

Continued Page 15

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

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Continued from Page 14

"Codeine-related deaths continued to rise when pharmacists were given responsibility for ensuring safe non-prescription codeine sales in 2010."

Dr Gannon said it is essential for public safety that the TGA is allowed and supported to make evidence-based decisions about medicines, free from political interference and sectional interests.

"As doctors, we rely on the independence and expertise of the TGA to ensure Australians have access to safe, effective, and high quality medicines.

"The codeine decision was made by independent experts whose only interest is what is best for Australians and their health.

"We call on all those who work in the wider health community – including pharmacy – to quickly implement the changes that are necessary," Dr Gannon said.

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10 August 2017

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ANTARCTICA

by Cheryl Ryan

Antarctica, the seventh continent is an astonishingly charming destination blessed with beautiful seascapes and landscapes. I

t is a wonderful dream for each adventure enthusiast to immerse in the extensive wilderness and spectacular wonders of this icy tourist spot.

The awe-inspiring landscapes of snow and ice certainly give you some unforgettable holiday experience to remember.

A supreme travel destination for adventure fanatics

Travelling to Antarctica is expensive, but it is also one of the spectacular continents in the world.

A trip to this majestic destination is truly exhilarating and its memories will be cherished in your mind for a long time.

Even when it is a distant and inhospitable place, it still offers several opportunities for the intrepid travellers to witness the beauty of this beautiful destination.

Explore the marvelous landscapes of Antarctic Peninsula and watch its rich summer wildlife of whales, seals and penguins.

Interaction with penguins can be the best thing that you can do during your trip to this majestic continent.

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A detailed itinerary has been designed that includes all the charming attractions in Antarctica and plenty of exciting activities.

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- Take exciting zodiac trips and shore landing in order to get close to natural environment.
- Sail into some of the famous bays in the continent and enjoy short trips down through scenic channels.
- Go for swimming at Deception Bay where the water is warm because of the dormant volcano.
- Hike up local hills to enjoy 3600 spectacular views.
- Enjoy different activities like kayaking, hiking and photographing wildlife.

Get ready to discover the wilderness of Antarctica!

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The Electronic Society

When I was in High School computers & mobile phones first started being used mainstream. We never had a computer at home and even throughout University I relied solely on computer rooms on campus.

Yes I am showing my age but below is how computer and mobile phones have affected the last 20 or so years in my occupation alone:

• Spelling and grammar no more. Its seems that with spelling and grammar checks people can no longer string a sentence together and spell even simple words like principle or principal correctly nor use them in the correct context. The art of English has been somewhat lost.

• Emails and texts. This is a minefield. Too often (and I include myself in this comment) both emails and texts are misinterpreted. Have you ever typed an email or text in all capitals simply because you couldn't be bothered taking the caps lock off, only to be berated by the recipient for yelling at them.

• It has become almost acceptable to send a text/email and quickly and easily dump a job and responsibility on the recipient. In my occupation I can receive up to 100 emails a day, granted it is my job to assist clients but emails like this are also received from banks, solicitors, ATO etc and the list goes on. If I had a dollar for every time a bank had requested financials only to respond to them that they received them months earlier, I would be a very rich person.

• Emails and texts can be totally devoid of emotion, or have misinterpreted intentions or in the event of an over user of emojii's, full of a mess of icons with no clear purpose.

• Emails and texts both save and waste time.

• Cyber crime. 2 words that put fear in most of us. We are constantly being reminded of our online vulnerability with warnings such as be wary of suspicious emails, check if websites are secure, change your passwords, avoid dodgy emails and links, use trusted mobile apps and keep anti-virus software up to date.

• Junk email. This is probably one of the biggest time wasters. Deleting it, unsubscribing to it and checking to make sure it is in fact junk.

• Internet connection is lost….. need I say more.

Figure 1 – Eisenhower's Urgent/Important Principle

As medical practitioners I am sure you are seeing more cases of the below conditions from computer or phone use:
- Shoulder, neck and back pain.
- Mental health issues caused from cyber bullying etc
- Sleep deprivation
- Repetitive strain injuries
- Eyesight issues.

And the list goes on.

I haven't looked into the statistics but prolonged use of computers and mobile phones are surely detrimental to our health?

So what is the point of my article? It is to prompt you to look within yourself and think about how computers and mobile phone use is affecting your lives? From what you discover in this process how computers/mobile phones are enriching your lives and how they are detracting from it? How you can improve and make your use of these more valuable and how you can ensure your communications with others are clear and concise.

Not all of you will agree with this article and that is ok. If all this article achieves is that it makes you think about your use then it was a success. For me I personally don't have the internet at home as I work on computers all day. When I send emails or texts I try to be clear, concise and human. And most importantly I try to stick to the below matrix:

If any of you have any feedback I look forward to hearing it.

Article written by Kerri Welsh, Manager Poole Group 07 54379900 kwelsh@poolegroup.com.au

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AMA

MANDATORY REPORTING AGREEMENT WELCOME: TIME FOR ACTION – AMA

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA welcomes the COAG Health Council decision to develop a nationally consistent approach to mandatory reporting provisions for health practitioners.

Federal and State and Territory Health Ministers have agreed to consult with practitioner and consumer groups, and develop a nationally consistent proposal for consideration at the next Health Council meeting in November 2017.

The agreement follows months of lobbying and advocacy from the Federal and State AMAs, highlighted by discussions in face-to-face meetings between Health Minister, Greg Hunt, and AMA President, Dr Michael Gannon, in recent weeks.

Dr Gannon said that the AMA has always advocated for treating practitioners to be exempted from mandatory reporting requirements.

“Mandatory reporting laws deter health practitioners from seeking early treatment for health conditions that could impair their performance,” Dr Gannon said.

“We have advocated long and hard at both the federal and State level for changes to the mandatory reporting provisions.

“It is an issue that the AMA and the whole medical profession feel passionately about. It affects every doctor, their families, their loved ones, and their colleagues.”

Delegates to the AMA National Conference in May were unanimous in seeking amendments to the mandatory reporting requirements under the National Law, so as to not dissuade medical practitioners from seeking necessary medical treatment or assistance.

The intention of the legislation was to ensure the protection of the public by requiring doctors and other health practitioners to report colleagues whose health was impaired.

But this created a barrier for health professionals to access health care, particularly in relation to mental illness. The lived experience of doctors’ health advisory services across the country confirms these fears.

“Mandatory reporting undermines the health and wellbeing of doctors,” Dr Gannon said.

“It is a tragic reality that doctors are at greater risk of suicidal ideation and death by suicide. This year we have lost several colleagues to suicide.

“While there are many factors involved in suicide, we know that early intervention is critical to avoiding these tragic losses.

“The AMA has identified that mandatory reporting is a major barrier to doctors accessing the care they need.

“The real work begins now. We need action from all our governments.

“The medical profession and the public need a sensible system that supports health practitioners who seek treatment for health conditions, while at the same time protecting patients.

“We urge all Health Ministers to work cooperatively to come up with an achievable agreed proposal at their next meeting.”

10 August 2017

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REDCLIFFE & DISTRICT MEDICAL ASSOCIATION INC
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RDMA Newsletter
JUNE 2015
President's Report Dr Kimberley Bondeson

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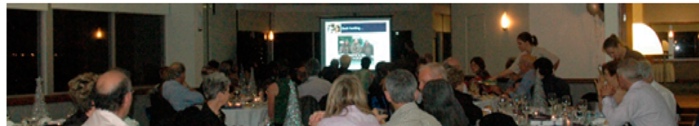

Dear Doctors

The Redcliffe and District Medical Association Inc. have had another successful year of interesting and educative meetings on a wide variety of medical topics. Show your support for your Local Medical Association to continue the only local convocation for general practitioners and specialists to socialise and to discuss local and national medico-political issues.

This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and speakers are most welcome. Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost.

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RATS OF TOBRUK: Continued

http://anzacportal.dva.gov.au/sites/default/files/rats-of-tobruk-transcript.pdf

Air Attacks
Bob Semple
And the Stukas gave us a fair sort of attention. They used the Stuka's reputation as a pretty accurate sort of a thing to defend their lines. It comes down to if you can imagine them screaming and opening every door and whatever apparatus they have got whilst they're screaming all the time. They come like a B-line at you, you watch the bomb come out from under the plane and so forth, its aiming straight at you like that and then they suddenly pull away.

Jack Caple
I was on guard on a waterhole which was not used and there was an "ack-ack" post not far away. And the Stukas used to come out of the sun, and they're at a blinding angle. And they pounded this 'ack-ack' regiment. There were sandbags and guns and bodies everywhere, my word there were. But there was an odd plane that didn't make it, but that pilot wouldn't know and they used to go around and back to base. They were very well trained.

John Fleming
We were sitting there and these five Stukas came over, anyhow. The first thing we knew, they were coming screaming down at this tent that we were sitting in. Outside we had holes dug, and that side was set up ready. But up in the hill area there it was that hard even when you had a shovel it was just alright but if you didn't you couldn't dig because it was too hard. And they dug little slit trenches that were very shallow, but it was okay you thought, with you thinking oh that's alright. We built it along like that and then across like this see. One could lie there and one could lie across here sort of thing. Anyhow, when I ran outside, there were blokes that beat me out and they filled up the trenches all around. So I dived in on top of one of the other blokes and I was still a bit above the floor. And as these bombs were coming down, you could hear as they had their sirens blaring. You knew they used to put these sirens on them. When they let the bomb go they'd just take 5 seconds, you know, 1,2,3,4,5 bang you're got it you know.

Jim Price
Another day we were there when Jack and I decided to go for a walk and we come to this big Wadi. You know a Wadi is a dry riverbed and we were walking along this and we heard a plane behind us and looked around here's a Stuka dive bomber. He was flying very low under the radar, and the next thing you know there's bullets all around us. And Jack and I, we headed for the bank. There were no trees or anything around, no rocks you could shelter behind but we broke the Stalwell Gift getting to that bank I can tell you. I thought he might come back but he didn't. We jumped out and bang bang after him but……

Reflections
Bob Semple
I reflect on these things, in your more sombre moments. You have your time when you reflect, and as you grow older of course but you never really forget.

Jim Price
It's something to be proud of I suppose.

Ernie Brough
I was never frightened, it's a funny thing, but never, ever frightened. No matter how tough it was, there was always a way out somehow or another.

Hautrie Crick
The siege of Tobruk was the longest siege that any British company or any British army had ever experienced, and I feel real privileged to be a Rat of Tobruk. And I've always said that and always feel that way, until my dying days actually.