RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
FEBRUARY 2017

Barry Gibbs Second Year Anniversary of Bronze Unvaeiling Page 20

See Where We Work & Live on page 20.
RDMA's Christmas Celebration

President's Report Dr Kimberley Bondeson

Greetings to everyone. What an interesting start to 2017!

We have glorious hot weather and blue skies. The storm season has not yet started.

Perhaps this is a prediction of the coming year for all Medical Practitioners. With the shock resignation and exit of the Federal Health Minister, Sussan Ley, and the instalment of the new Federal Health Minister, Greg Hunt What will the year reveal?

It feels like Groundhog day, repeating again and again. We have a new Federal Health Minister, so the re-education process begins on the Health portfolio for the new Health Minister, and the Medical Profession waits to see what this will bring.

We have fascinating international politics, with the election of President Trump, and his dramatic and controversial changes to American politics. We also have the exit of the United Kingdom from the European Economic Community (EEC) - which as yet, has to be played out.

It is such a different world from 20 years ago when I first entered the medical profession. We now have APRHA, which appears to have created itself.

The Medical Board of Australia wants to protect patients from 'poorly performing doctors' - by unknown and unproven means.
Private Health Insurance Premiums are about to go through the roof in terms of cost - there are not enough intern positions, and too many Australian Medical Graduates.

We still have the basic problems of not enough training places, nor enough doctors willing to go and work in rural areas - which existed 30 years ago. However, the situation with intern positions is a new development over the last few years.

We are seeing the legalisation of medical marijuana, discussed by Dr Herdy in this issue of RDMA. And we are also watching with interest the development of a public forum and discussion for legalisating euthanasia.

We will follow these topics with issue over the next 12 months!!
Welcome to 2017.
Kimberley Bondeson,

RDMA & NLMA's Joint Newsletter

Welcome from

Dr Robert (Bob) Brown

President Northside Local Medical Association

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

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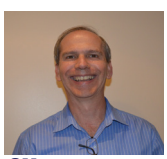

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RDMA 2017 MEETING DATES:

For all queries contact Kristina Craner or Anna Wozniak Meeting Conveners: 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

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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 22nd February 2017

New RDMA Meeting Convener

Ms Anna Wozniak,

CONTACT DETAILS:
MOBILE: 0466 480 315
EMAIL:ANNA.WOZNIAK@QML.COM.AU

02.12.16 Dr Kimberley Bondeson, RDMA President introduced Mrs Margaret McPherson and thanked her for her excellend and ongoing contribution to RDMA and LMA members as the RDMA Meetings Coordinator and selfless devotion to the memberhip. RDMA's Executive thanked and farewelled Margaret MacPherson wishing her all the best in her new QML Position. Margaret also handed over to her new Co-Meeting Coordinator and sucessor Ms Anna Wozniak

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 22nd February 2017**
TIME: 7pm for 7.30pm
VENUE: Regency Room - The Ox, 330 Oxley Avenue, Margate
COST: Financial members - 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: CPAP Direct
7.40pm	Speaker: Dr Andreas Fiene - Thoracic, Transplant & Sleep Physician Topic: An update on respiratory & sleep medicine
8.15pm	Main meal, question time
8.40pm	General business, dessert, tea & coffee

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 28th of March 2017**
TIME: 7pm for 7.30pm
VENUE: Regency Room – The Ox, 330 Oxley Avenue, Margate
COST: Financial members - 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: Bayer
7.40pm	Speaker: Dr Jason Butler - Haematologist BMT/Clinical Haematology Unit, Cancer Care Services RBWH Topic: Deep issues of the venous kind
8.15pm	Main meal, question time
8.40pm	General business, dessert, tea & coffee

RSVP: By Friday 24th of March 2017
(e) RDMA@qml.com.au or (ph) 0466 480 315

INSIDE THIS ISSUE:

AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

MEDICAL MARIJUANA LEGISLATION 2017.

Medical marijuana is about to be legal in Queensland, commencing 1st March. GP's are already being approached by patients demanding that their doctor give them access to their rights to obtain legal prescribed, marijuana, and presumably at taxpayers' expense.

I attach the information available on the Queensland Health website. I make no apologies for burdening my readers with an extra two pages, but this information tells you all that most doctors will ever need to know, and it is actually well written for a government statement so I can't improve on it. If you think you will be targeted by patients demanding prescriptions for medical marijuana, you must read this relatively short statement at least once.

For those who do not already know, I have to disclose my personal biases:

(a) I have an addiction practice. To be more precise, about a quarter of my patients have a problem with addiction or with long-term use of controlled substances. I am seen to be an "expert" but am really only a family GP with a higher-than-average experience of the subculture that uses illicit drugs. Despite my denial, the drug-using subculture on the Sunshine Coast has already labelled me as a "specialist" for the purpose of the Act. I am not.

(b) I have never used any illicit substance myself, including marijuana. My friends know me as an incredibly boring person who has never smoked a cigarette or even had a single alcoholic drink in my life. I am eminently unqualified to judge the use of any drugs from personal experience.

(c) Because I serve a particular demographic, every patient who has approached me for my support of the use of MM has been a patient already using marijuana for recreational purposes. A high proportion of them have a marijuana addiction. In my biased perception they are universally seeking to have a legal justification for their pre-existing illegal habit. It is probably secondary to them that they might be hoping to obtain their drug of choice at taxpayer expense.

(d) Until I can see some hard science, I am not interested in being involved in writing prescriptions for MM.

The critical points

- Marijuana is available legally but only under very limited circumstances. The Act defines "a cannabis product" incredibly broadly, including literally any cannabis preparation as long as it has a therapeutic intent.
- Appropriately qualified specialists can get a generic approval as "patient-class prescribers" to prescribe MM for any patient, but the Act is vague about which specialists can prescribe MM. The classes of specialists who can be approved will be made clear only after the Act comes into force on 1st March.
- GP's can only get approval to prescribe MM for individual patients, as "single-patient prescribers", but only in conjunction with a specialist.
- Every prescription has to be approved by the chief executive, which means going through the same process that we all have to go through to prescribe S8 drugs, ie a conversation with Medicines Regulation and Quality (MRQ, formerly DDU). Unlike routine scripts for opioids or other S8's, the chief executive can require an additional specialist opinion.
- MM does not have a TGA approval, so every prescription will have to be written with an individual TGA approval.
- Unless prescribed as required by this Act, marijuana is still illegal in Queensland.

I am troubled by the requirement to obtain MRQ approval. Firstly, I doubt that MRQ is adequately resourced to handle its present roles with regard to conventional S8 medications, let alone to manage what I think will be a surge of workload with requests for approvals for MM prescriptions. Secondly, my special position in the medical workforce has demonstrated to me that most doctors do not submit reports or request authorizations for the familiar S8 prescriptions, and that MRQ is not resourced to pursue every prescriber who breaches the rules, even habitual repeat offenders. So I must wonder if prescribers will even make the correct application to prescribe, or if MRQ will be able to respond to the new workload.

Any doctor who believes it is appropriate to prescribe MM to a particular patient for a particular medical condition will find the administrative hurdles difficult and time-consuming. I can only

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AMAQ BRANCH COUNCILLOR REPORT Continues from P5
Dr Wayne Herdy, North Coast Councillor

speculate on how the requirement to obtain individual TGA approvals is going to work.

Any GP who wants to resist a patient's demands should find it easy enough to take refuge behind the rather tall hurdles that the Act has put in place. Specialists will need to be more robust than GP's in their refusal, because the Act does not yet define what specialists are expected to be qualified, nor which medical conditions are expected to be treated with MM.

As I read the present state of play:
- Most prescribers remain incredibly confused about what is happening with legalized MM. I hope that a single read through the attached government website material will resolve most of the confusion.
- Most prescribers want to avoid being deluged by an influx of patients, whether genuine or established addicts, demanding prescriptions. I hope that my advice above makes it easier to rebut unwanted advances.
- A few (and it looks as if it is very few) prescribers want to explore uncharted but hopeful territory to find a remedy for patients whose complaints presently defy conventional medicine. Those prescribers will have to follow the regulations precisely or face punitive consequences. As soon as word is out that identifiable prescribers are prepared to prescribe MM, those prescribers should expect a tsunami of new patients.

The official AMA position on MM is regrettably wishy-washy. The AMA accepts that there may be some benefit in MM for some patients, but advocates further research before it can adopt a more conclusive position.

The Queensland government has opened a real Pandora's box with this piece of legislation. Only time will tell if the legislation eventually achieves its intent, to find relief for those patients whose needs have so far not been met by conventional medicine.

If you open the Queensland Health website https://www.health.qld.gov.au/system-governance/legislation/reviews/medicinal-cannabis
this is what you will read:

Public Health (Medicinal Cannabis) Bill 2016

The Public Health (Medicinal Cannabis) Act 2016 (PDF, 1.23MB) was passed by Queensland Parliament on 12 October 2016. The Act will commence on 1 March 2017.

The Act creates a new regulatory framework to allow medicinal cannabis products to be prescribed and dispensed to patients in Queensland and prevent unauthorised use of these products. Any cannabis used outside of the regulatory framework is illegal.

The Act balances allowing greater use of medicinal cannabis products, and ensuring medicinal cannabis products are used safely and not diverted for unlawful purposes.

The regulatory framework will be reviewed after 2 years to:
- ensure it is meeting the needs of patients,
health service providers and enforcement agencies
- reflect any developments in the evidence base.

Prescribing medicinal cannabis:
Medicinal cannabis can be prescribed and dispensed now. This is made legally possible under the amendments made to the Health (Drugs and Poisons)Regulation 1996 (HDPR) (PDF 1.4MB). Once the Act comes into effect on 1 March 2017, the HDPR provisions will be repealed.

The Act provides 2 pathways for doctors to be authorised to prescribe medicinal cannabis:
- Patient-class prescribers:
specialists who have an "as-of-right authority" to prescribe to groups of patients for a specified condition or symptom with specified medicinal cannabis products
- Single-patient prescribers:
specialists or general practitioners can apply for approval to prescribe for a particular patient.

Approval from the Therapeutic Goods Administration (TGA) and Queensland Health is required before medicinal cannabis can be prescribed by an approved doctor and supplied by an approved pharmacist.

Medicinal cannabis will only be approved:
- the patient has tried all of the conventional treatments available and these have failed OR
- the conventional treatment causes intolerable side effects
AND
- the doctor

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Dr Wayne Herdy, North Coast Councillor

provides clinical evidence that a specific type of medicinal cannabis product is effective for the particular condition or symptoms

Re-scheduling medicinal cannabis products
Medicinal cannabis products have been re-scheduled from S9 to S8, allowing these products to be incorporated into the existing regulatory framework for using S8 substances. These amendments have been made to the HDPR, and have been replaced with corresponding provisions in the Act, when the Act takes effect from 1 March 2017. Cannabidiol (CBD) is an exception; it is an S4 drug but because it is a medicinal cannabis product it is covered by the Act.

Most S8 substances are registered on the Australian Register of Therapeutic Goods. To be registered, a drug must undergo extensive safety and efficacy testing. Scheduling alone does not make a substance eligible for registration.

Most medicinal cannabis products are unapproved therapeutic goods, and will stay unapproved even if they are re-scheduled from S9 to S8. Therefore, the Act includes additional safety and security controls around the use of these products:

- approval process for medical practitioners under the single-patient prescriber pathway
- expanded reporting requirements for specialists under the patient-class prescriber pathway.
- all medicinal cannabis products must only be dispensed from an approved pharmacist or a hospital pharmacy.

Monitoring and enforcement
The Act includes monitoring and enforcement controls to ensure medicinal cannabis products are not used illegally. These controls are consistent with other legislation.
Consultation
The Queensland Government undertook a consultation process with the public, patients, doctors, pharmacists and other key groups in the first half of 2016.

A draft Bill (PDF, 588KB) was then reviewed by the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee and further public comment was sought.

The discussion paper (PDF, 400KB) explains the proposed regulatory framework in the Act:

- regulation of medicinal cannabis, including the relationship between the proposed Queensland regulatory framework and relevant Commonwealth laws
- Australia's international obligations under the Single Convention on Narcotic Drugs 1961
- Commonwealth legislation which establishes a licensing scheme for the lawful cultivation and manufacture of medicinal cannabis in Australia.

Background
The Queensland Government was the first in Australia to enable access to unregistered medicinal cannabis products containing THC for therapeutic use in Australia.

This was made possible by changes tothe HDPR in December 2015, which allowed:

- clinical trials to use medicinal cannabis products
- therapeutic use approved by the TGA Special Access Scheme and Queensland Health.

This approval to prescribe is given to the treating doctor for a particular patient. Further changes to the HDPR in June 2016 allowed specialist doctors to prescribe medicinal cannabis forcertain limited classes of patients.

The Act replaces these temporary arrangements from 1 March 2017.

Cannabis is still illegal
The Queensland initiatives ensure that foundations are in place to make it possible to access medicinal cannabis treatment. The new regulations mean there are strong controls around treatment with medicinal cannabis.

These changes do not broadly legalise cannabis. Any cannabis grown, supplied or used outside of the proposed regulatory framework, at the Commonwealth and State levels, will remain illegal, regardless of the motive.

Wayne Herdy

Branch Councillor

North Coast Branch

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Revalidation and Medical Indemnity Fund, Health Care

The Medical Board of Australia spokesperson, Dr Flynn, states that there "'is more to be done" to protect patients from poorly performing doctors.

However, I have not seen any real evidence to support any proposed revalidation, nor any evidence that a revalidation process such as that which is in place in the UK makes any difference to protecting patients from poorly performing doctors.

The Federal Government is also in the process of reassessing it's financial support for medical indemnity.

The Indemnity Insurance Fund was set up in 2002 following the indemnity crisis, which had resulted in soaring premiums, and the near collapse of United Medical Protection.

The Federal Government has announced that they would raise the threshold for the High Cost Claims Scheme from $300,000 to $500,000.

Under the scheme, the government pays insurers 50% of every claim over the threshold.

A high threshold will obviously save the government money, but it means that the private insurers will increase premiums to recoup losses.

We need to watch this space carefully, as there was no consultation with the medical profession on any of these proposed changes by the government.

It could result in extremely high Medical Indemnity insurance for medical practitioners, which may price some professions out of the system altogether.

There does not appear to be any progress on unfreezing the Medicare rebate freeze.

Though I note with humour the following extract from the Australia Doctor's latest 3 February 2017 edition

"'Hunt in the hot seat – Minister for GP's. Bad starts.

I think the public want him to be the minister for the pubic, and, in particular, patients.

Unfreezing their rebates would be a good start.

The previous minister tried to undo the freeze by sunbaking on the Gold Coast.

Hopefully, this one has a different plan. Donald Rose".

Sincerely

Kimberley Bondeson

LMA Newsletter Column Continued P11

Structural issues – not staffing – plague maternity services.

Despite serious incidents and near misses regularly occurring in public maternity health services, the Queensland Government is overlooking both the extent and the root cause of the problem.

In January, Health Minister Cameron Dick vowed to conduct a statewide review of midwife staffing levels throughout the state following the tragic death of a newborn.

While this is an important first step in reducing maternal and infant deaths, it ignores the core issue – that midwives throughout Queensland are working without obstetrician supervision or input.

This is not a recent crisis and the Health Minister is aware of AMA Queensland's concerns. Last October, we recommended a number of changes to the way public maternity health services were delivered, purely to improve outcomes for mothers and babies.

AMA Queensland has since repeated these concerns in meetings with the Health Minister. So, what will it take for the Health Minister to take decisive action?

Last June, an independent clinical review of four incidents at Rockhampton Base Hospital identified issues including a failure to assess expectant mothers correctly and to notify obstetricians promptly when complications arose or labour was not progressing .
These issues could be easily addressed by implementing the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) guidelines for when problems or concerns need to be raised with an obstetrician but, to date, Queensland Health has failed to do so.

The problem does not lie solely in midwife staffing levels. It lies in the Government's commitment to a midwife-only approach that current Australian and overseas research shows is not the best model of care.

Several research studies show that preventable trauma and deaths are continually occurring under midwife-led models of care . Here in Queensland, 11 babies in every thousand die in the public system, compared with seven per thousand in the private hospital system .

Queensland's private hospital system has a true multidisciplinary model of care, with obstetricians and midwives working together. Our public system has abandoned this model, which is a grave mistake that must be corrected.

The Australian College of Midwives has argued that outcomes between public and private systems cannot be compared due to differences in populations and models of care .

The Health Minister himself has said that mothers in the public system are more likely to have complex needs and chronic conditions such as obesity and diabetes .

And this is precisely our point – it is even more important for obstetricians to be involved from the outset. This doesn't take away a woman's right to choose how she wishes to give birth. But, when research shows the best outcomes for mothers and babies are achieved by maternity care teams led by an obstetrician , it is irresponsible to sideline the only health professionals who can pre-emptively handle whatever complications arise during pregnancy and birth.

An expectant mother in Queensland's public system can go through her entire pregnancy and birth without ever being examined by an obstetrician.

Even in a 'low risk' pregnancy, however, complications may develop that midwives simply are not trained to handle. In fact, recent Australian research shows that in about half of pregnancies assessed as low risk, an obstetrician will need to step in to deliver the baby safely .

If an obstetrician is involved early on, complications may be anticipated and mitigated before they become serious. This is not 'medicalising' pregnancy and birth – it is simply providing the best level of care we can offer. In many cases, early intervention may save the life of the mother, the baby, or both.

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MEDICAL MOTORING

WITH DOCTOR CLIVE FRASER

Safe motoring,
doctorclivefraser@hotmail.com.

"The Chicken Tax "Subaru Brumby (1978-1994)!""

On 20th January 2017 Donald Trump took over the reins of the US Presidency. He promises to protect US manufacturing by imposing heavy tariffs on imported goods, particularly cars coming from Mexico.

This isn't the first time this has happened with President Lyndon B Johnson imposing a 25% tariff in 1963 on imported light trucks. LBJ's tax was also on potato starch and brandy and occurred in response to a decision by France and Germany to impose a tariff on the importation of chicken from the USA. Thus the so-called 'Chicken Tax' began and it still exists on imported light trucks today.

In Australia our light trucks are mostly made in Thailand, but in 2016 the US made Ford F-Series is still America's top-selling vehicle (820,799 were sold) helped along by a hefty tariff on imported competitors. So in 1978 in the midst of a US Trade War along came Fuji Heavy Industries with a popular utility called the Brat (in the US) and the Brumby (in Australia).

The lateral thinkers at Subaru thought that if they fitted two seats in the utility tray that would make the Brat/Brumby a passenger vehicle and a tariff of only 2.5% would be applied. Well, that ploy worked until 1985 when the welded in rear seats were finally discontinued. Fast forward to 2017 and Australia and there seem to be Subaru Brumby's cropping up everywhere.

I've just been on a central Queensland cattle property where I found two of the beasts. The first one was bought new in 1989 for about $14,000 plus on road costs. Standard equipment included a bull-bar and a radio-cassette player. It's done 282,000 kilometres. It has no rust and it still runs like a dream.

It might have an over-heating issue because of a 28 year old radiator cap not holding the pressure, but every morning it started and every day it went wherever we pointed it over the roughest terrain. Sure the paint was faded and a respirator was required if the blower fan was turned on as years of dusty debris flooded the cabin. But every dial, switch and knob still worked. Not bad after nearly three decades sitting in the Queensland sun.

Checking out the cargo area this Brumby also had the jump seats fitted. But there were no seatbelts. Not to worry because the seats weren't bolted down either as they were from a Nissan and cost $2. After all this Brumby wasn't registered and never left the farm. The jump seats were surprisingly comfortable and it was advisable to hang on tightly when travelling in the rear.

After spending the day mustering and spraying weeds in the Subaru Brumby it came back to The Shack every evening to rest. Just before putting the old girl to sleep I was reminded by its owner to wind up the windows to discourage various species of snake from slithering into the car and relaxing under the dashboard. I must say that I never forgot this ritual lest I find a Carpet Python or a King Brown dropping onto my legs in the morning.

So if owning one Brumby is a good thing wouldn't it be better to have another one for spares. Well the owner does have a second car that doesn't run (just in case). But the more I looked at the second car the more I realized that it shouldn't be euthanized and that it still had potential as a restoration project, and not just as an organ donor. After 28 years a Subaru Brumby in reasonable condition is still worth about $7,000.

This equates to annual depreciation rate of 2% which proves that in terms of residual value the Subaru Brumby was probably the best value motor vehicle purchase of 1989.

Safe motoring,
Doctor Clive Fraser

There are valid medical reasons for an obstetrician being involved in every pregnancy and we need not spend a single extra cent to use our currently employed obstetricians more effectively.

That is why AMA Queensland is calling for a truly independent review of Queensland's maternity services, conducted by an impartial expert. We believe the Government must undertake this immediately and fearlessly, without prejudice or favour, without worrying about the election cycle or fostering an impression that everything is fine. AMA Queensland wants to work together so that every mother-to-be has the best possible care and the best possible outcome – a healthy baby.

Australian Medical Association Queensland

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LETTERS TO THE EDITOR

CONTINUED PAGE 13

2nd February 2017
RDMA Newsletter

Dear Editor
Dr Chris Zappala, the President of AMAQ, has replied to my letter regarding mandatory CPD requirements for GPs in the December Edition of DoctorQ magazine, which I would like you to publish for the benefit of our readers.

By now I trust all the doctors have read my letter dated 8/11/2016 to the President of RACGP, Dr Bastian Seidel which you published in the December 2016 RDMA Newsletter. Clearly I do not agree with the AMA stance on this issue which I consider unacceptable and I have asked the AMA to reconsider its position. Our readers will be most interested to read my reply (attached) to Dr Zappala.

Yours Sincerely
Dr Mal Mohanlal

You were born original, don't die a copy – Anonymous. In fact most people do. Read "The Enchanted Time Traveller - A Book of Self Knowledge and the Subconscious Mind "by Dr Mal Mohanlal and learn how to manipulate your subconscious mind to make yourself happy. Be a true scientist, not a pseudo-scientist. Visit website: http://theenchantedtimetraveller.com.au/

Dr Chris Zappala
President
AMAQ 3/01/2017

Dear Dr Zappala

Thank you for your response to my comments on the mandatory CPD requirements for GPs in the new triennium (Doctor Q- December 2016).

The Medical Board of Australia and the Council of Australian Governments are both mindless bureaucratic bodies that have no clue what so ever and have no interest what so ever in how the human mind operates and what learning is all about. Their only function is to regulate the medical profession to give the public the impression that by complying with their rules the medical profession would be providing a higher standard of care.

How unscientific, naïve and puerile can one get and are the AMA and the Colleges willing to accept that? I would not and the reason why is stated in my recent letter dated 8/11/2016 (attached) to the President of RACGP. As yet I have not received any reply from him. All doctors should read my letter and ignore this new requirement. They should write to the College to support my stance if they wish to be mentally healthy, independent and free individuals in their own right.

I would like you to publish this letter in DoctorQ as it may help doctors clear up their perception of what role we should be playing in society. To impose more bureaucratic mandatory requirements on busy already stressed doctors reflects sheer disregard for the mental health of people who are supposed to look after the mental health of society. If that is not a bullying tactic of the lowest kind, I do not know what is.

Do our judges and the legal profession have any mandatory CPD requirements or any CPD requirement at all? How do they self-regulate?

Self-regulation does not mean that we have to self-flagellate or invent other methods of self-torture every triennium to prove to the world that we are doing the right thing. That is just plain humbug and being sadistic.

Unless the medical profession can wake up to its responsibilities instead of playing politics with devious thinking politicians and bureaucrats, I cannot see how we can help society improve its mental health.

It is time for the AMA to reconsider its position on this issue. Will the AMA support my stance or am I just barking up the wrong tree?

Wishing you a happy New Year and kind regards

Yours sincerely

MAL MOHANLAL

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- Bisphosphonate Infusions
- Supportive intravenous therapy
- Blood Transfusions
- Blood product support
- Patient education and support
- Supportive Allied health services Dietician, Exercise and Massage

Meet Our Team

Dr John Reardon
Medical Oncologist/
Clinical Haematologist
***SC**

Dr Hong Shue
Medical Oncologist
***SC**

Dr Sorab Shavaksha
Clinical Haematologist
***SC**

Jesse Goldfinch
Excercise Physiologist
***SC**

Dr Rosanne Middleton
Clinical Health Psychologist
***SC**

Dr Peter Davidson
Consultant Haematologist
***NL**

Dr Kieron Bigby
Medical Oncologist
***NL**

Sarah Higgins
Dietician/ Nutritionist
***SC**

Dr Darshit Thaker
Medical Oncologist
Palliative Medicine Specialist
***NL**

Dr Lydia Pitcher
Haematologist/ Oncologist
Paediatric Haematologist
***SC**

Tania Shaw
Oncology Massage Therapist
***SC**

Dr Raluca Fieser
Clinical and Laboratory Haematologist
***NL**

Dr Geoff Hawson
Medical Oncologist
Clinical Haematologist
Palliative Care Physician
***NL**

Be Our Guest

Sunshine Coast Haematology and Oncology Clinic is delighted to be supported by the McGrath Foundation through the provision of the McGrath Breast Care Nurse, who is available to help community members and their families through breast cancer by providing free advice, support and care when it's needed most.

North Lakes Haematology & Oncology Clinic
Tel: (07) 3833 6755 | www.nlhoc.com.au
7 Endeavour Bvd, North Lakes Q 4509 (next to OzCare)

Sunshine Coast Haematology and Oncology Clinic
Ph: 07 5479 0000 | www.schoc.com.au
10 King Street, Buderim, 4556

The Medical Journal of Australia • MJA
MEDIA RELEASE

TIME FOR NATIONAL OBESITY ACTION PLAN

EMBARGOED UNTIL 12:01 am Monday, 13 February 2017

THE lack of a coordinated national approach to the Australian obesity epidemic is "unacceptable", according to the Chair of the Council of Presidents of Medical Colleges, writing in the *Medical Journal of Australia*.

Laureate Professor Nick Talley chaired the recent National Health Summit on Obesity, which established a six-point plan of action:

- Recognition of obesity as a chronic disease with multiple causes: remove stigma, focus on prevention (especially in children) and maximise access to optimal disease management.
- Education and upskilling: build health professional capability in the prevention and management of obesity by upskilling through education and training, provide disease management toolboxes, and fund clinical research to identify new evidence-based prevention and treatment strategies.
- Health professionals leading by example: encourage health professionals to lead by example with initiatives across universities, hospitals and health services, including reducing access to sugar-sweetened beverages and processed foods on site, and promoting a greater variety of fresh foods and water as healthier choices for staff, students and visitors.
- Pre-conception planning: focus on prevention before and early after birth, provide obesity prevention and care for all women as part of routine perinatal care (and women and men before conception), and provide support services after birth via a nationally funded strategy.
- National obesity prevention strategy: develop and adopt a new comprehensive evidence-based strategy including a focus on diet, exercise and healthy cities (bringing health expertise to the table to maximise the benefits of new urban planning).
- Stronger voluntary regulation and new legislation: incentivise voluntary food reformulation and support food ratings, reduce unhealthy food marketing to children, reduce the consumption of unhealthy high sugar beverages and foods by implementing a sugar-sweetened beverage tax, and use the funding to support the entire plan.

"It is time now that Australian health care professionals, organisations training future health care professionals, and government at all levels begin looking at what we can do together; the six-point plan is a start," Professor Talley wrote.

"The current lack of a coordinated national approach is not acceptable."

Professor Talley is also the editor-in-chief of the *MJA*.

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.

CONTACTS: Laureate Professor Nick Talley 02 4921 5855
University of Newcastle, HMRI Building

Quebec, Canada

The Walled City

by Cheryl Ryan

A charming city beaming with vibrant culture, heavily accented by its French heritage, Quebec is the most popular destination in North America. Its convivial people, beautiful rolling hills, colourful Victorian facades, romantic bistros, and vivacious winter season make it an instant hit amongst travellers. Quebec has something exciting in store for every kind of adventurer there is. Be it getting knee-deep in history, treating the foodie in you with scrumptious delicacies, hanging out with nature or, daredevilry at Quebec's outdoor adventure playground, Quebec will surely be a thrilling entry in your diary!

Fascinating Outdoor Adventure

1. Old Quebec: Captivating ancient architecture, the enchanting Château Frontenac, historic attractions, the unique sight of street performers at the open-air art gallery, Dufferin Terrace overlooking the St. Lawrence River, and Rue du Tresor …much more awaits you at Old Quebec.

2. Parc de la Chute-Montmorency: Take a gondola ride over the majestic Montmorency Waterfall and feel the force of the roaring waters, as well as relish the beauty of île d'Orléans and the St. Lawrence River. The brave-hearts may try ice climbing up the frozen cliff.

3. île d'Orléans: Its picturesque beauty – resembling Quebec's 19th century countryside – is highlighted by baroque churches, heritage homes and historic farms. While you are at it, indulge in its famous apples, strawberries and blackcurrant liqueurs!

4. Camp out in Portneuf and Laurentians wildlife reserves or, visit the Parc national de la Jacques-Cartier, and enjoy hunting, wildlife watching, mini-rafting, hiking, canoeing, fishing or simply relaxing.

5. Battlefields Park: It is one of the largest and finest urban parks in the world, and hosts many activities like cross-country skiing, and cycling.

6. Vallée Bras-du-Nord: Check out the waterfall, the snaking river, and scenic peaks in this enchanting valley in Portneuf. For a stronger dose of adrenaline, explore the 70 km long grid of tracks, ride a horse, kayak or canoe down the river or, hit the mountain bike paths!

7. Le Massif de Charlevoix: This spectacular mountain overlooking the enchanting St. Lawrence River offers a surreal experience of skiing down its snow-blanketed slopes facing the river!

8. Cap Tourmente National Wildlife Area: Behold the mesmerizing sea of snow geese that flock the area during spring and autumn. Watch out for over 300 species of birds here. Get your camera and binoculars ready!

Winter Wonderland

Quebec transforms into a magical snow-world during winters, which is ideal for skiing, dogsledding, snow-mobiling, snow fishing, and snowshoeing. The world-renowned Quebec Winter Carnival, Ice Hotel, and Valcartier Vacation Village are other star attractions.

What have we planned for you?

A comprehensive itinerary has been developed to include all the exciting attractions of Quebec.

• Guided trip through Parc de l'Esplanade, along the perimeter of the town walls between the two historic gates – Porte St-Jean and Porte St-Louis – to the Citadelle.
• Visit Parc de la Chute-Montmorency, and Parliament Hill including, Parliament Building, Fontaine de Tourney, and Observatoire de la Capitale
• Organised trip to Old Quebec
• Trip to the Plains of Abraham, and Musée des Plaines d'Abraham
• Tour of the Place-Royale – Quebec's ancient town square, and Musée de la Civilisation – Quebec's finest museum
• Shopping at Rue St-Paul

www.123Travelconferences.com.au

FBT YEAR END IS FAST APPROACHING

It's well known that the tax law can become complex at times. One specific area that accountants receive many questions on is Fringe Benefits Tax (FBT). So what is FBT? FBT is a tax employers pay on certain benefits they provide to their employees, including their employees' family or other associates. The benefit may be in addition to, or part of, their salary or wage package.

FBT is separate to income tax and is calculated on the taxable value of the fringe benefit provided. The FBT year runs from 1 April to 31 March; It's like the ATO don't know what simplicity is!

FBT law includes various categories of fringe benefits and specific valuation rules apply for each category. Some of these include car fringe benefits, entertainment fringe benefits and expense fringe benefits. Car Fringe Benefits are by far the most common fringe benefit . Below is a brief explanation on how car fringe benefits work.

A car fringe benefit most commonly arises where you (the employer) make a car you 'hold' available for private use of an employee (or the car is treated as being available). A car you hold generally means a car you own or lease.

The following types of vehicles (including four-wheel drive vehicles) are cars:

- Motor cars, station wagons, panel vans & utilities (excluding panel vans and utilities designed to carry a load of one tonne or more);
- All other goods-carrying vehicles designed to carry less than one tonne;
- All other passenger-carrying vehicles designed to carry fewer than nine occupants;

You make a car available for private use by an employee on any day that either:

- The car is actually used for private purposes by the employee
- The car is available for the private use of the employee (e.g. car is garaged at the employees home)

There are two distinct methods to work out the taxable value of the benefit used; statutory formula method & operating cost method. The statutory method is based on the car's cost price where as the operating cost method is based on the costs of operating the car throughout the FBT year. The Statutory method is predominately used as it requires less record keeping.

Once you have worked out your taxable value of the benefit used you need to gross up the value by either:

- FBT Type 1 – 2.1463 (This rate is used where the benefit provider is entitled to goods and services tax (GST) credit)
- FBT Type 2 – 1.9608 (This rate is used if the benefit provider is not entitled to claim GST credits)

Once the above is complete all that is left to do is multiply the taxable amount by the FBT rate (currently 49%). *FBT is an expensive way to provide an employee with a motor vehicle, a more cost effective and simpler solution may be to provide your employee with an allowance on top of their salary instead.*

Below is a helpful link which goes into FBT in a lot more detail and outlines the various types of Fringe Benefits available:
https://www.ato.gov.au/General/Fringe-benefits-tax-(FBT)/

FBT can become quite confusing! Please do not hesitate to contact one of our friendly Tax Specialists on 07 5437 9900 if you have any questions.

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Set Funding Targets For GP Services Research - AMA

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA Position Statement on General Practice in Primary Health Care

The AMA has called on the Government to set a target for funding GP services, to deliver extra funding for general practice research, and to set up a centre of excellence in general practice and primary care research.

AMA Vice President, Dr Tony Bartone, today released the AMA Position Statement on General Practice in Primary Health Care, which outlines the key elements and central role of general practice in the delivery of quality primary health care services in Australia.

"General practice is the cornerstone of a successful primary health care system, and must be funded adequately," Dr Bartone said.

"GPs are the first point of medical contact for most Australians, and a visit to the GP can head off more serious health problems down the track.

"Evidence shows that populations in countries with strong general practice have lower rates of ill-health and mortality, better access to care, lower rates of hospital readmissions, and less use of emergency services.

"GPs are becoming increasingly important as the population ages, and there is an increase in the burden of chronic disease requiring long-term care.

"GPs are managing more problems and spending more time with patients in each consultation than they did a decade ago as patients, particularly those who are older or have chronic diseases, present with multiple reasons for their visit.

"Yet funding for general practice is not growing to match rising demand. The Medicare rebate freeze is putting pressure on practices that bulk bill, and is set to stay in place until 2020.

"This combination of rising demand and shrinking funding will inevitably lead to a decline in the ability of general practice to provide quality health care, unless the Government delivers real resources to frontline GP services.

"Commonwealth Government funding for GP services currently stands at about 8 per cent of the total Government health budget – a modest investment that is delivering excellent outcomes for patients.

"The AMA is proposing that this figure should be lifted over time to a target of around 10 per cent, as part of an effort to re-orientate the health system to focus more on general practice and primary health care, with long-term savings to the health budget anticipated in return.

"The AMA is also calling for a dedicated stream of funding for general practice research.

"General practice is a distinct medical specialty and requires its own specific research. Research improves patient care, is important for teachers of general practice, and stimulates intellectual rigour and critical thinking.

"It is the missing link in the development of high quality, evidence-based health care for populations.

"About 2 per cent of National Health and Medical Research Council (NHMRC) grants are directed to supporting primary health care research, including general practice.

"This is woefully inadequate, and is well below the contribution of general practice and primary care to the broader health system.

"The AMA believes that general practice and primary care deserve a much fairer distribution of NHMRC funding.

"We are calling for a dedicated stream of general practice research funding in the order of 8 per cent of its grants budget.

"This funding must be backed by the establishment of a national centre of excellence in general practice and primary care research."

The AMA Position Statement on General Practice in Primary Health Care is available at https://ama.com.au/position-statement/general-practice-primary-health-care-2016.

12 January 2017

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REDCLIFFE & DISTRICT MEDICAL ASSOCIATION INC
MEMBERSHIP SUBSCRIPTION BENEFITS

ABN: 88 637 858 491

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Don't waste time! Join now!

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Get Your Membership Benefits! Socialise! Broaden your Knowledge!

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.

RDMA SUBSCRIPTION FORM - INTERNET PAYMENT PREFERRED

Treasurer Dr Peter Stephenson Email; GJS2@Narangba-Medical.com.au

ABN 88 637 858 491

1. One Member (July to June: $120.00; Oct to June: $90.00; Jan to June; $60.00; April - June: $30.00)
2. Two Family Members ($20.00 Discount each) ($200 pro rata) (Please include each person's details)
3. Doctors in Training and Retired Doctors: FREE

1. Dr _____

(First Name) *(Surname)*

Email Address: _____

2. Dr _____

(First Name) *(Surname)*

Email Address: _____

Practice Address: *Postcode:* _____

Phone: *Fax:* _____

CBA BANK DETAILS: Redcliffe & District Medical Assoc Inc: BSB 064 122 AC: 0090 2422

1. PREFERRED PAYMENT METHOD: INTERNET BANKING

2. PAYMENT BY DEPOSIT SLIP: INCLUDE your name: ie: Dr F Bloggs, RDMA A/C and Date

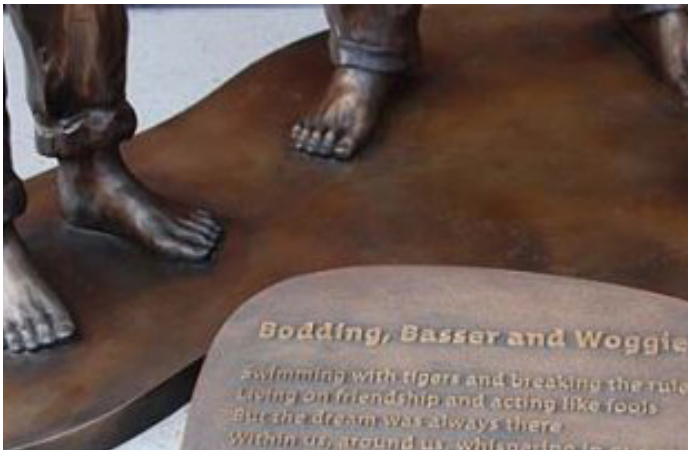
3. ENCLOSED PAYMENT: (Subscription Form on website, type directly into it and email)

i) Complete Form and Return: C/- QML or RDMA at PO Box 23 Redcliffe 4020

2) Or Emailing to GJS2@Narangba-Medical.com.au

Where We Work and Live

Barry Gibbs Remembers His Bare Foot Days 14/02/2013



A fourth anniversary of the homecoming for Redcliffe's favour son. Barry remembers his barefoot days as the Bee Gees are celebrated in bronze This Barry Gibb tour is certainly a hallmark as Barry revisits his families past. He is reconnecting with his childhood memories and passing comment on the formative years of the Bee Gees to the next generation of his extended family. "The thing I like best about the bronze stature it is that we're barefoot," Gibb told a throng of reporters. "That's how we all lived."

Gibb smiled as he officially revealed the Phillip Piperides sculpture of himself and twin brothers Robin and Maurice, captured from a photo of the trio making music in their grassy backyard circa 1959. His sister Lesley, standing close by their 93-year mother Barbara, burst into tears. Gibb's wife Linda, their daughter Alexandra and son Stephen all looked on with pride.

As Gibb went on to involve them all in the unveiling of the new Bee Gees Walk, a 50-metre lane linking Redcliffe Parade to Sutton Street filled with photographs and memories of the group's 50 year history, it became very much a family affair; a reunion of the Gibbs young and old, with special thoughts for the brothers no longer with them.

But it was also about acknowledging Redcliffe, the seaside town northeast of Brisbane that the Gibb family migrated from England to, and which Barry Gibb described as their "paradise". Gibb, wearing a shiny black jacket, impeccably pressed white shirt and straw hat, seemed faraway at times as he remembered the scrapes and hijinks of he and his brothers. "You never imagine something like this," he said, crediting Mayor Sutherland with bringing the project to fruition.