REDCLIFFE & DISTRICT and BRISBANE LOCAL MEDICAL ASSOCIATION

RDMA & BLMA's Joint Newsletter

Newsletter
June 2020

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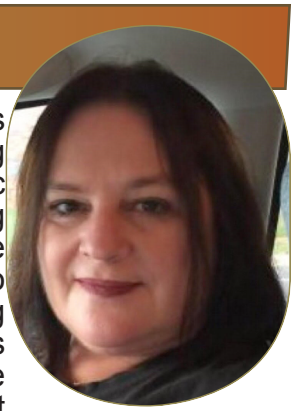
RDMA President's Report Dr Kimberley Bondeson



It seems a long time since the beginning of May, when Australia was still in the middle of the upsurge on the Covid 19 pandemic. Australia has recorded 28 cases of the Covid 19 infection over the last week – more than half of them are travellers returning from overseas, and already quarantined in hotels, according to the Chief Medical Officer, Dr Brendan Murphy. Restrictions in Queensland are slowly lifting – we are now allowed to travel throughout regions, restaurants are allowed 10 inside and 20 outside (depending on their size), schools have reopened, gyms are re-opening, albeit with restrictions. It seems Australia has missed a bullet, for which I am extremely grateful. A repeat of what happened in Italy, or what is occurring in the UK would have been disastrous. And the people who made this happen, were our Federal Health Minister, Greg Hunt, on the advice of the Chief Medical Officer Professor Brendan Murphy, to close our international border with China, on 1st February, 2020. Was this the right thing to do? The increasing death rates of other countries suggest that it was. Italy, New York, London, Spain have all reported over 1000 deaths a day each for several weeks, with their ICU beds swamped and their hospital and health system not coping, and large numbers are still dying daily. Countries like Sweden, who are relying on herd immunity, are still having large numbers of citizens die daily, and their economy is suffering just the same as its neighbours, which did not rely on herd immunity.

There is definitely a toll to the social distancing restrictions and closing down of the economy, which has resulted in mass unemployment and loss of businesses which we now face into the future. Lifting of restrictions is slowly occurring worldwide. The EU is talking about opening its domestic borders from Monday, Egypt is reopening select tourist destination to international charter flights from 1st July. Australia is allowing international students back into the country on a "pilot basis".

Our GP and Specialist clinics are slowly ramping up, along with private and public hospital clinics and operating theatres. My patients are definitely looking forward to the specialist clinics doing face to face consultations – on average, they are reporting that the specialist telehealth consultations are not very satisfactory, especially for complex medical conditions, where they are unable to be examined. And particularly difficult if the Doctor has not met the patient in person previously. In my practice, we do not allow telehealth consultations for patients we have never seen before, they need to be seen in person first. Of course, there are exceptions, (palliative care and end of life care patients), I am aware that other practices are working out what works best for them. And we are still not allowing anyone with flu like symptoms to be seen in person, they are contacted by telephone first. So, it is a new world. However, telehealth has its place, and hopefully is here to stay. There are many elderly as well as rural patients who are benefiting from it.

Kimberley Bondeson

RDMA & BLMA's Joint Newsletter

Welcome from

Dr Robert (Bob) Brown

President Brisbane Local Medical Association

Note: Doctors in Training RDMA Membership is Free

RDMA & BLMA Meeting Dates Page 2.

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

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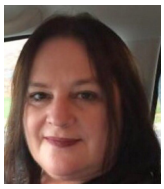

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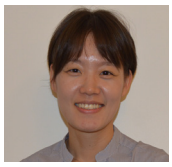

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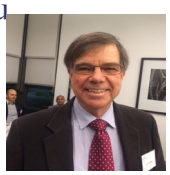

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CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Tuesday	February	25th
Wednesday	March	25th
Tuesday	April	28th
Wednesday	May	27th
Tuesday	June	30th
Wednesday	July	29th
ANNUAL GENERAL MEETING - AGM		
Tuesday	August	25th
Wednesday	September	30th
Tuesday	October	27th
NETWORKING MEETING		
Friday	November	20th

NEWSLETTER DEADLINE

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BLMA 2020 MEETING DATES:

For all queries contact Graham McNally Meeting Convener: Phone: (07) 3265 3111
Email: gmcnally1@optusnet.com.au

W:https://www.brisbanelma.org/

CPD Points Attendance Certificate Available

Venue: Riverview Restaurant, Bris
Kingsford Smith Dr & Hunt St in Hamilton

Time: 6.30 pm for 7.00 pm

ANNUAL GENERAL MEETING - AGM		
1	February	11th
2	April	14th
3	June	9th
4	August	11th
5	October	13th
NETWORKING MEETING		
6	November	27th

INSIDE THIS ISSUE:

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- No charge to current RDMA members.
- Non-members $55.00

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RDMA VICE PRESIDENT'S REPORT
Dr Wayne Herdy,

CHANGES TO PBS RULES FOR OPIOID PRESCRIPTIONS.

On 1st June, the rules regarding PBS prescribing of opioids changed. We had no notice this was going to happen. The software providers had embargoed notice two weeks earlier, but their software was not upgraded until 2nd June.

This set of changes produced massive confusion and wastage of resources. It also promises to overload GP's for at least the next three months, and compromise continuity of supply to patients.

I won't go through all the changes, but I do need to explain a few.

Firstly, all longer-acting opioids (modified-release formulations and patches) are now authority scripts. Admittedly, they are streamlined authorities, so for a lot of prescribers this change will have little immediate effect.

But the streamlined authority scripts only provide two weeks' medication, and by definition practically all patients on the long-acting formulations are long-term consumers.

Will every one of them have to return every two weeks (or at least have a telecon every two weeks)? Not an act of kindness to patients with chronic pain, most of whom are elderly and suffer multiple morbidities.

Life gets considerably more complicated if the prescriber has been prescribing one or three months' supply at a time on authority scripts (one month on phoned authorities, 3 months on mailed-in authorities).

I don't have the numbers, but I suspect that includes almost all chronic pain patients on long-term opioids. Maybe hundreds of thousands of patients nation-wide, and a lot of them are in nursing homes.

All existing authorities ceased to have effect.

Cancelled.

The patient's next script will have to be a two-week script. So, until the prescriber gets a new authority, those patients will require a consultation or visit every two weeks, to replace an authority script that previously lasted 3 months.

Prima facie, this will need thousands, maybe hundreds of thousands, additional consultations and additional prescriptions until we sort out the mess. And the additional administration at the pharmacy end is hardly much better.

To get the next authority script, the prescriber will have to get a second opinion from another prescriber, unless the opioid prescribing has already been reviewed in the past 12 months.

Until now, we had to get that second opinion review when the authority scripts reached the 12-month point. Once.

Now we have to get the review every 12 months. There is a transition provision – for the next three months, I can still get a one-month telephone authority script if I can tell the HIC that the patient will have a review by another prescriber. But I have to be able to tell them the name of the reviewing prescriber and the date of the appointment.

Get real, please. How practical is it for me to be able to arrange a review by another prescriber when I have no control over that prescriber's appointment book?

And if there are 100,000 chronic pain patients in the country already receiving authority scripts (my guess, not real data), then we will have to produce an additional 100,000 appointments within the next 3 months. And

Next Meeting Date 30th June 2020

Monthly Meeting

Cancelled

Redcliffe & District Medical Association Inc.

RDMA VICE PRESIDENT'S REPORT
Dr Wayne Herdy,

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we'll have to do it all over again in 12 months' time (at least for those patients who are still alive).

The HIC knew this was coming, but they weren't ready for it. On day one, the operators on the authority line were dutifully asking the seven questions for every application. By Monday evening, the impatience and frustration experienced by the operators was getting palpable.

I had some lovely chats with a few of the operators, who had already learned to hate the system even more than the prescribers did. The wait time to get an answer on the authority line was passing 10 minutes by Monday night. On Friday night, a few of my calls nearly hit the 30-minute wait. Even filling in time doing something else while I was on speaker phone, my days have been ending hours later than normal.

Clearly the system is grossly overloaded and under-resourced.

And why?

There are overseas precedents for similar measures. We are all aware that politicians are sensitive to unsubstantiated media campaigns about over-prescribing of opioids. Two drugs stand out as having received bad publicity, mostly undeserved. OxyContin was targeted by the media even after the formulation was changed to make diversion more difficult. And fentanyl (one of the safest and most effective long-term opioids when used properly) causes more deaths, used intravenously and improperly, than heroin.

But if 50,000 prescribers Australia-wide are prescribing more opioids than the politicians like, there is a reason for it. Those 50,000 prescribers, all intelligent people with a decade or more of training behind them, and years or decades of practical clinical experience, have decided that the medications work, that our patients need them, and that used wisely they are relatively safe.

There is limited evidence (if any) that imposing strict prescribing rules is going to save lives – this is almost totally a data-free zone. We admit that people die from improper use of opioids, but the data is that most opioid deaths occur when a legally prescribed opioid is misused, usually diverted, and often by a person for whom the opioid was not prescribed. Show us the data that impractical and onerous prescribing rules will save lives. And can anybody explain to me why these changes were dropped on the profession from a great height without notice? This is hardly an insider trading secrecy environment.

A final whinge. If prescribing of long-term opioids is forever going to be more difficult, we will see even more paranoia among young prescribers, even worse pain management in the community, and even more reluctance for decent doctors to take up the challenging roles of chronic pain management and palliative care. Thanks, Mister PBS, the Australian public really needed all of this.

Wayne Herdy

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NEW FREE, CONFIDENTIAL MENTAL HEALTH COUNSELLING SERVICE FOR DOCTORS AND MEDICAL STUDENTS

Doctors and medical students around Australia now have access to free, confidential telehealth mental health services through the new Drs4Drs Support Service, which has been established by Doctors' Health Services Limited (DrHS).

"While we encourage all doctors and medical students to have their own GP as their first point of contact for any health problem, we know that some don't have a regular GP, may be geographically isolated, or are reluctant for many reasons to discuss mental health concerns with others," AMA President and DrHS Board member, Dr Tony Bartone, said today.

"The availability of a confidential, non-judgmental service that makes it much easier to access mental health support, particularly for those located in rural areas, is a very important step forward, particularly with the impact that the COVID-19 crisis is having on frontline healthcare workers."

The Drs4Drs Support Service provides crisis support as well as non-urgent mental health support, and complements services provided by the network of State-based doctors' health advisory services that are also funded by DrHS.

DrHS Chair, David Brennan, said that corporate mental health provider, Converge International, will deliver the Drs4Drs Support Service, deploying mental health professionals who are experienced in helping people work through workplace issues, conflict management, relationship concerns, financial problems, legal matters, and lifestyle issues.

"Converge International was able to demonstrate significant experience in this area and will use a team of psychologists, counsellors, and social workers who are experienced in providing support to medical professionals," Mr Brennan said.

"All services funded by DrHS are completely confidential. DrHS does not receive any information that could identify anyone using this service, as we appreciate patient privacy is paramount, and we provide the option of anonymity."

DrHS is a subsidiary of the AMA, established with funding from the Medical Board of Australia to provide health and wellbeing support to medical students and doctors.

The Drs4Drs Support Service is funded by a grant from the Federal Department of Health, allowing participants to have up to three free telehealth counselling sessions.

Accessing the Drs4Drs Support Service is simple. Doctors and medical students can call 1300 374 377 (1300 DR4 DRS) or visit Drs4Drs.com.au - a national one-stop-shop for wellness and support resources for the medical profession.

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9 June 2020

CONTACT: DrHS - Christine Brill 0407 123 670

The Medical Journal of Australia • MJA
MEDIA RELEASE

FOLLOW-UP OF INDIGENOUS ICU PATIENTS AFTER DISCHARGE VITAL

RIGOROUS follow-up of Indigenous patients recovering from critical illness, particularly those who have discharged themselves from hospital, is essential, according to the authors of research published online today by the *Medical Journal of Australia*.

Researchers from Melbourne, Adelaide and Boston in the US, analysed of intensive care unit (ICU) patient data (Australian and New Zealand Intensive Care Society Adult Patient Database), prospectively collected during 2007–2016, measuring mortality (in-hospital, and 12 months and 8 years after admission to ICU), by Indigenous status.

"The median age of Indigenous patients (45 years) was lower than for non-Indigenous ICU patients (64 years). For patients with South Australian postcodes, unadjusted mortality at discharge and 12 months and 8 years after admission was lower for Indigenous patients; after adjusting for age, sex, diabetes, severity of illness, and diagnostic group, mortality was similar for both groups at discharge, but greater for Indigenous patients at 12 months and 8 years. The number of potential years of life lost was greater for Indigenous patients (24.0 v 12.5), but, referenced to respective population life expectancies, relative survival at 8 years was similar," the researchers found.

"Our major findings are that, after adjusting for major demographic and clinical factors, in-hospital mortality was similar for Indigenous and non-Indigenous intensive care patients, but mortality at 12 months and 8 years after admission was greater for Indigenous patients.

"Higher levels of chronic disease, remoteness, lower socio-economic status, and difficult access to health care for Indigenous patients are probable contributors to higher long-term mortality.

"Comparable studies have reported similar differences in age, chronic disease status, and intensive care admission diagnoses for critically ill Indigenous Australians, as well as a greater burden of chronic disease after episodes of critical illness."

They concluded that: "The factors underlying the overall gap in life expectancy between Indigenous and non-Indigenous Australians are more important than the impact of the ICU admission itself for determining long term outcomes for Indigenous patients."

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Dr Chris Perry
President AMA Queensland
and
Jane Schmitt,
CEO AMA Queensland

Introducing your new President, Board and Council

Following AMA Queensland's Annual General Meeting on 22 May, we welcome our incoming President Dr Chris Perry and Vice President Dr Bav Manoharan and congratulate Dr Eleanor Chew on her appointment as Chair of Board and Council and Dr Nick Yim as Member Appointed Director. We also congratulate our new Councillors and welcome back those returning to another year in their representative roles.

You can find the full list of AMA Queensland Board and Council representatives at www.amaq.com.au.

All the doctors listed are your representatives as an AMA Queensland member. If you have any ideas, concerns, issues or feedback, you contact them through AMA Queensland secretariat by email at a.sanderson@amaq.com.au or phone (07) 3872 2222, or contact them directly through Queensland Doctors' Community.

Change to AMA Queensland leadership team

After more than 11 years of extraordinary service, our Chief Executive Officer Jane Schmitt has informed the AMA Queensland Board of Directors and Council of her intention to depart her role at the end of August. In early September, Jane will take up a new role as Executive Director, External Relations for Mater Group in Brisbane.

AMA Queensland will keenly feel the loss of Jane’s knowledge and expertise, however, we will continue to reap the benefits of her visionary work which has steered AMA Queensland through a decade of growth and transformation.

A lawyer by profession, Jane has been committed to upholding robust governance standards and maintaining a solid financial position. Importantly, she has led the organisation from the front and has built strong stakeholder relationships and enduring commercial partnerships for AMA Queensland, which underpin our organisation’s continued success.

AMA Queensland’s capacity to deliver information and assistance to our membership has also been greatly enhanced by investment in technology. Throughout her tenure, Jane has enabled the delivery of a variety of new digital platforms, including Queensland Doctors’ Community and the new AMA Member App launching in June.

Jane’s sharp intellect, boundless energy and passion for this organisation, its staff and membership has been remarkable. She will be sorely missed. Her tenacity during challenging times, from the current COVID-19 pandemic to controversial doctor contract negotiations in 2014, has delivered outcomes that have served to strengthen our profession.

In turn, Jane has derived a great deal of personal and professional satisfaction from her time at the helm of AMA Queensland. She has conveyed her deep appreciation for the enormous support she has been given by members and staff, the Leadership Team, Board and Council over many years.

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Jane will continue to lead the organisation over the next three months while the Board engages in an executive recruitment process to secure a high quality candidate. In the meantime, AMA Queensland remains in a strong position with a stable team of talented, diligent staff and large group of volunteer members who serve on Council.

We wish Jane great success and have no doubt we will find ways to collaborate further in future to continue enhancing outcomes for patient care in Queensland.

AMA Member app live in June

We are pleased to announce that AMA Queensland is about to launch the first-ever AMA Member app.

The new app 'AMA Community' will provide members with a new and exclusive experience to connect and engage with each other and the AMA in real time.

The app will be available for both iOS and Android and will serve as an AMA member hub for content, networking, collaboration and events. Members will have access to dedicated news feeds and forums, a member directory with in-app direct messaging, one-click event registration and easy membership renewal.

Through the app, members will also be able to download workplace resources and access all their member benefits and discounts, and access Queensland Doctors' Community (QDC) - all in one place and at the touch of a button.

The AMA Member app will be live on 21 June, so keep an eye out for launch details coming shortly.

New member benefit – IGA discounts

We are pleased to announce the launch of an exciting new partnership between AMA Queensland and IGA Supermarkets.

IGA are offering all AMA Queensland members a 5% discount on IGA Gift Cards purchased online via the AMA Queensland website.

To access the offer, log on to www.amaq.com.au with your AMA username and password and select the IGA Gift Card online offer. Select the amount you would like to purchase and add to the cart. The 5% discount will be automatically applied.

We encourage you to take advantage of this offer, as we look to continue to expand our range of benefits and services available to members.

Dr Chris Perry, President AMA Queensland **Jane Schmitt, CEO AMA Queensland**

The Medical Journal of Australia • MJA
MEDIA RELEASE

VITAMIN D DEFICIENCY TESTING ON THE CLIMB AGAIN

THE number of tests for vitamin D deficiency is on the rise again despite measures taken in late 2014 to restrict testing to people at particular risk of vitamin D deficiency, according to the authors of a Perspective published online today by the *Medical Journal of Australia*.

The number of tests for vitamin D deficiency in Australia rose steeply between 2000 and 2011, from 0.4 to 36.5 tests per 1000 population; the cost to Medicare increased from $1.1 million in 2000 to $95.6 million in 2010, and peaked at $151 million in 2012–13. Consequently, the Medical Benefits Schedule (MBS) items for testing (66608, 66609) were replaced in November 2014 by new items (66833–66837).

“The immediate effect of the new criteria was that the rate of vitamin D tests was 47% lower during 2014–16 than during 2013–14,” wrote the researchers, led by Professor Rachel Neale, Group Leader of Cancer Aetiology and Prevention at QIMR Berghofer Medical Research Institute.

“Medicare data indicate that the testing rate has since increased, by 34% between 2015 and 2019, from 119 to 159 tests per 1000 population, and the cost to Medicare rose 42%, from $73.7 million to $104.7 million.

“The testing rate increased in all states; the rate for women increased by 30% (from 164 to 214 tests per 1000 population), and for men by 40% (from 74 to 105 tests per 1000 population). The most marked increases were for people aged 85 years or more, for whom the 2019 testing rate exceeded the 2012 levels. Testing rates for people aged 0–25 years did not markedly change between 2015 and 2019.

“The marked overall increase in testing since 2015 is not explained by changes in demographic or clinical factors, suggesting that at least some screening is unnecessary and that ordering doctors are either unaware of or do not support the new MBS vitamin D testing criteria,” Neale and colleagues wrote.

“Evidence-based guidelines and MBS policy, accompanied by education and audit activities, have failed to contain the level of vitamin D testing.

“Further, people who are socio-economically disadvantaged or at particular risk of vitamin D deficiency, including Indigenous Australians, are still tested less frequently than other Australians.”

The authors concluded that people at clear risk of vitamin D deficiency could be treated without testing, especially as the cost of supplementation -- $2.25 per month – is only a fraction of the cost of testing ($30.05).

“High quality research is needed to provide evidence for informing interventions to curb the use of low value tests in a health system that encourages a high volume of services, but not necessarily better value care,” wrote Neale and colleagues.

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Corona – The Making of The Bogeyman
By Dr Mal Mohanlal

After this coronavirus lockdown do you feel spooked? Are you afraid to go out and mix with people or go out shopping, thinking you might catch the virus? Are you anxious and fearful of the world around you? If you feel unaffected, then you have done well. But there are a lot of people who think differently about the world around them. It is because their thinking and perceptions are affected, and thus their mental health.

There are various types of thinking involved. We have emotional thinking, philosophical thinking, scientific thinking, bureaucratic thinking, political thinking, intuitive thinking, rational thinking, wishful thinking etc.

Each type of thinking can lead an individual into different directions and jump to different conclusions. But if you are interested in improving your mental health, rational thinking is the way to clear up confusion and chaos in your mind. Rational thought takes into consideration all other types of thinking.

First, let us consider emotional thinking. Here you are doing what your heart says. There is no rhyme or reason involved. You will not be open to any sensible argument or suggestion. If you go along this path, please be prepared for heartaches and tears.

Then there is philosophical thinking. Here you are involved in trying to find the reason for your being in this world and how you can organise and live your life according to some principles established for you to follow. It can be a path to creating a delusion.

In scientific thinking, we are concerned with understanding the nature of things and our physical world and how the forces of nature affect us physically and mentally. There are a lot of people who claim to be scientists but are in fact pseudo-scientists. They hide behind science and use science as an ego-boosting exercise. So any scientist who ignores the mental side of their being is likely to have little insight into their mind. When one has little or no self-knowledge, one can quickly to turn into a bureaucrat. We see this in evidence everywhere in the world.

Of course, the most potent and influential thinking is legal thinking which is bureaucratic thinking. It has a powerful conditioning effect on the individual. Since we need the rule of law to run any society, we formulate rules and regulations for ourselves to avoid chaos. Hence where there is a traffic junction, for instance, we put a STOP sign. Where we see some danger on the road, we put a speed limit sign.

All this is to help us use our commonsense. So if one is at a traffic junction, one should look to the left and right before entering. Also, if there is a speed limit of 100km per hour, it does not mean that one has to drive at 100km per hour. One has to consider the road conditions at whatever speed one can drive. Again one can see that we have to use our commonsense in whatever we do.

However, this legal thinking has one major drawback. That is, when we apply the law in any situation, only the letter of the law is followed. There are no considerations for the use of any morals, commonsense or ethical principles.

It is simplistic thinking which limits one's intelligence. Hence when we come to a STOP sign, it means literally full stop even if there is no traffic. The vehicle must not be moving, and if you are driving slightly above the 100km per hour speed limit sign means that you are breaking the law. You will get penalised. We call this bureaucratic thinking.

The reason for this type of bureaucratic thinking in law where only the letter of the law and not the spirit, is applied is to avoid any arguments or confusion. It protects the people administering the code from any prosecution. All they have to do is to stick to the letter of the law, and no one will blame them if anything goes wrong.

It also induces in some people authoritarian and bullying type of behaviour because they feel empowered by being able to enforce the law. So does it mean that if one sticks to the letter of the

Corona – The Making of The Bogeyman
By Dr Mal Mohanlal *Continued from page 12*

law one cannot go wrong?

Let us see what the coronavirus crisis did to the medical profession. Once upon a time, there was a direct doctor-patient relationship. The need for any euthanasia laws, for instance, did not arise because the doctor did what was clinically best for the patient.

Now with consumerism and the litigations laws prevailing, the medical thinking has changed. The doctors have become bureaucratic thinkers. They are conditioned to think that they have to save lives no matter what the cost even if they see a patient in pain starving to death with a terminal illness.

So when the coronavirus hit the scene, it spooked the doctors by the way it spread and caused deaths. They feared the hospitals and the health systems would not be able to cope with the resources they had. So they advised governments to go into lockdown. The governments also got spooked.

Faced with the choice between saving human lives and damaging the economy, they saw no alternative but to go into lockdown. It would have been political suicide if they did not take action.

Do you think this was a rational decision?

Remember, the damage to the economy will have far greater significant consequences for society than all the lives saved from Covid-19. There will be long term physical and mental health consequences in terms of poverty, crime and violence and suicides.

With the lockdown came more rules and regulation. Bureaucratic controls are applied, and businesses close. People become unemployed. The media gets a field day reporting on the progress of the virus. Every day, 24 hours a day, on the radio, TV and in the newspapers one can only hear about the virus. It now seems everyone is spooked. Covid-19 has become the bogeyman of the 21st century. Not willing to admit its overreaction, the medical profession keeps justifying its action by implying that this virus is unlike the influenza virus. All their research seems to be directed at validating their bureaucratic thinking. Many people who died of other causes but tested positive for coronavirus become included in their statistics.

Spooked politicians also justify their actions by using the virus as a bogeyman. They now have found a way of controlling the population. The bureaucrats having vandalised the economy, are proudly pointing out how successful they have been in protecting you. They are already taking credit for starting to rebuild the economy. Yes, one can never win against bureaucracy. In the meantime, you are warned that if you do not follow their directions, the bogeyman will get you.

So let us look at this bogeyman. It is the Covid-19 virus infection. There is no known cure for any virus infection. Like the influenza virus, it kills people. All virus infections tend to spread, so one has to expect this virus to spread.

All the measures we have taken only slows down the virus. They do not eliminate or kill the virus. Like any virus, this Covid-19 will affect people with a weak immune system. The elderly and people with co-morbidities are more affected than the young. When we return to some normality in socialising, this flattened curve of infection is sure to rise. Like the influenza virus, it will come and go.

Does it then mean that the country has to go into lockdown again when the curve of infection rises? If someone is found Covid-19 positive in a workplace, does it mean we have to close down the whole place? If one child is found Covid-19 positive in a classroom, do we close down the entire school? If someone who is feeling perfectly healthy and who has a Covid-19 App on his mobile receives a message that he was near a Covid-19 positive person. He is advised to get tested for the virus. What must he do?

Are we not going to create anxiety in that person until he gets the test done? Is this not like asking a person to point a bone at oneself? Is this the

GREATER OCCIPITAL NERVE SYNDROME

By Dr Philip Dupre

This condition is not widely recognised but is often the cause of chronic headaches and even migraine attacks. It is easily treated with immediate and dramatic relief of symptoms.

Typically the patient complains of pain which passes from the occiput, over the top of the head, to the frontal area. It is often but not always, associated with watering of the eyes.

There can be referred pain to the neck or upper jaw. One lady I saw recently was on a dental waiting list to have all her top teeth removed because she had severe ongoing pain in this area.

The critical diagnostic sign is suboccipital tenderness which is well localised. It is probably worth testing this routinely in anyone with chronic headaches or a migraine attack.

The treatment is simply to localise the site of maximal tenderness which is usually bilateral, and inject half an ampoule of cortisone mixed with an equal volume of local anaesthetic, i.e. one ml. of mixture into each site. It is important to move the needle point on the bone surface until the trigger point is found.

I have on occasions had patients with a severe migraine headache find immediate relief from this injection.

There are very few textbooks that mention this condition. The Internet gives more information but complicates the issue with too much theoretical and anatomical detail so in this article I have purposely avoided going into this.

Finally, it is useful to know that there is an item number to claim for this injection. (18242.)

Corona – The Making of The Bogeyman

By Dr Mal Mohanlal *Continued from page 13*

way to go about improving the mental health of society? Is this the way to the future?

Surely we have to accept the fact that we have to take risks all the time in our daily living. When we are crossing the road, we are taking a risk. When we are driving a car, we are taking a risk. Also when we are travelling on a bus or plane, we are taking a risk.

Then why have we turned this coronavirus into a bogeyman? Since the medical profession is the guardian of the physical and mental health of people, should it not be involved in protecting us from this bogeyman instead of joining with the politicians into promoting one?

Fear is the worst enemy of man. It creates negative feelings and thus leads to adverse action. We have to confront it, not embrace it. The medical profession should be educating the public about the virus, not helping to create a bogeyman to look under their beds. Also, does not the media carry any responsibility in all this?

There will be more viruses to come to infect society in the future. Are we going to go into lockdown each time? Remember, a spooked mind is a mind that is suffering from a disorder of perception. How can one expect it to think rationally?

Please read the new second edition of the “The Enchanted Time traveller - A Book of Self-knowledge and the Subconscious Mind” and learn how you can manipulate your subconscious mind.

Visit the website: Http:\\theenchantedtimetraveller.com.au. The eBook version is also available at Amazon.com.

Discover CROATIA & The Alpine Countries

by Cheryl Ryan

A place for all tastes!

Croatia is a part of Eastern Europe that offers diversity to its travelers through its beautiful deep blue waters, sparkling waterfalls from Dinaric Alps, and the gorgeous medieval architecture.

Whether you want to lie on a sun-kissed beach or perhaps get the essence of it through its Middle Ages towns or sit amid serene nature, Croatia will leave you delighted with its many things on offer!

Sun, Sea, and Sand!
Croatia has beaches of all kinds, from pebbly to sandy beaches, ideal for family fun or for those who want to lay in seclusion to soothe the heart and core.

Following are some of the must-visit beaches on your trip to Croatia:

1) Zlatni Rat Beach: The Europe's third popular beach, Zlatni Rat Beach is a half kilometer long beach, ideal for families.

2) Banje, Dubrovnik Banje is a pebbly and sandy beach, offering breathtaking views across the sea. Enjoy a swim in the crystal clear waters or just laze around on the beach the entire day!

3) Sunj, Dubrovnik: Surrounded by lush green Mediterranean forest, Sunj beach in Lopud with shallow waters, ideal for children, families, and those who want to experience adrenaline rush through plenty of water sports.

4) Dubovica, Hvar: One of the most gorgeous beaches and only a few kilometers away from the lively town of Hvar, the Dubovica beach is a must-visit beach for all.

If you love diving or want to explore the colorful underwater sea life, Dubovica it is!
Pamper your History and Culture Loving Self!
1. Hvar: The longest island in Adriatic Sea, Hvar houses some beautiful historical monuments that will pamper your history loving core. Some of the places to visit in the city include The Square of Hvar, Fortress, The Cathedral of St. Stephen, and The Franciscan Monastery.

2. Zagreb: Comprising museums, art galleries, churches, and many other architectural splendors, Zagreb is a must-visit city for history and art lovers. From the city's popular Mimara museum, 13th century old Lotrscak Tower, to baroque church and plenty of art galleries and museums, you will have a great time in Zagreb exploring its gorgeous centuries old sites.

What have we planned for you?
We have formulated a fun-filled and comprehensive itinerary that includes the best of Croatia:
- Guided and historical trip to Zagreb, the capital city of Croatia.
- Visits to the National Parks of Croatia as the country is abundant in national parks. Some of the must-visit parks include Plitvice Lakes National Park, Krka National Park, and Paklencia National Park
- Tours to the UNESCO World Heritage sites, such as the Old City of Dubrovnik.
- A visit to the beach, Zlatni Rat Beach, in the region of Dalmatia, popular for its unusual shape and picturesque beauty.

Tour Dates: 12 June – 5 July

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123 TRAVEL CONFERNCE

2020 End of Financial Year Checklist – Superannuation

Concessional Contributions Cap

The concessional contributions cap for the 2020 financial year is $25,000. Concessional contributions can include the following:

- Employer superannuation guarantee – compulsory contributions made by the employer at 9.5% of ordinary time earnings.
- Award contributions – specified in employment awards or agreements.
- Salary-sacrifice contributions – paid from your pre-tax income to your super fund.
- Personal contributions – claimed as a tax deduction in your personal tax return.

Please ensure contributions are paid by no later than 25 June 2020. This will allow sufficient time for processing. The contribution will only be accounted for once it has been received by the employees' super fund.

If you exceed the concessional cap, the excess is included as assessable income in your personal tax return. Tax will be paid at your marginal rate less the 15% tax that has already been paid in the super fund. You have the ability to release the excess amount from the super fund to pay the additional tax. Please speak to your tax accountant to discuss your options.

Unused Concessional Contributions Cap

From 1 July 2018 if your total superannuation balance is less than $500,000 on 30 June from the previous financial year. You have the option of contributing above the $25,000 cap if you have an unused portion from the previous 5 years.

Description	2017-18	2018-19	2019-20	2020-21	2021-22
General contributions cap	$25,000	$25,000	$25,000	$25,000	$25,000
Total ususued available cap accrued	Not applicable	$0.00	$22,000	$44,000	$69,000
Maximum cap available	$25,000	$25,000	$47,000	$25,000	$94,000
Superannuation balance 30 June prior year	Not applicable	$480,000	$490,000	$505,000	$49,000
Concessional contributions	$0.00	$3,000	$3,000	$0.00	$0.00
Unused concessional cap amount accrued in the relevant financial year	$0.00	$22,000	$22,000	$25,000	$25,000

https://www.ato.gov.au/Rates/Key-superannuation-rates-and-thresholds/?anchor=Concessionalcontributionscap#Concessionalcontributionscap

Concessional contributions can only be made on behalf of an individual in the following circumstances:

- Aged less than 65 years.
- Satisfy the work test if they are aged between 65 to 74 years. The work test requires the individual to be gainfully employed for a period of 40 hours within 30 consecutive days in the financial year before a contribution can be made.
- Have sufficient taxable income if the individual intends to claim the concessional contribution as a deduction in their tax return.

Superannuation Guarantee Amnesty

A one-off opportunity to correct past unpaid superannuation guarantee (SG) amounts. Employers have access to a six-month window, until 7 September 2020, to disclose, lodge, and pay unpaid SG amounts for their employees. Employers are able to claim deductions for the amounts paid, and not incur administration charges or penalties during this period.

Pensions

If you receive a pension from a superannuation fund, please ensure that you have withdrawn the minimum pension prior to 30 June. The minimum pension is calculated by multiplying the pension account balance by a percentage factor.

Age	2013-14 onwards	Reduced rates by 50% for the 2019-20 and 2020-21 income years
Under 65	4.00%	2.00%
65-74	5.00%	2.50%
75-79	6.00%	3.00%
80-84	7.00%	3.50%
85-89	9.00%	4.50%
90-94	11.00%	5.50%
95 or more	14.00%	7.00%

https://www.ato.gov.au/Super/Self-managed-super-funds/In-detail/SMSF-resources/SMSF-technical/Pension-standards-for-self-managed-super-funds/

If you have any questions feel free to call our office. 07 54379900.

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NRL JULY CROWDS PLAN BELONGS IN THE SIN BIN

AMA President, Dr Tony Bartone, said today that the National Rugby League (NRL) plan to have crowds of fans back watching live NRL Premiership matches at suburban grounds by July is a huge risk to public health and should be abandoned.

“Put bluntly, this absurd and dangerous idea belongs in the sin bin,” Dr Bartone said.

“The NRL should be satisfied that it has its competition back in action, but it is unfair and unwise to put the health of the game’s fans at risk.

They must first monitor the health and safety of the players and officials who will be involved in the thick of the on-field action.

“Australians have done exceptionally well in flattening the COVID-19 curve, and we are not too far away from relaxing more restrictions.

“Now is not the time for sporting codes to be considering having crowds at games. They must wait until the medical experts advise that it is absolutely safe to do so – and that will not be as early as July.

“The AFL and other sporting codes are adopting the right approach, which is to wait for the expert medical advice before allowing crowds back to watch games.

“We have to be consistent in our public health messaging.

“Decisions on the safety of holding mass gatherings should be made by medical experts in consultation with the National Cabinet, not by rugby league administrators.

“Of course, we all want to see sport return with fans in the stands barracking for their teams.

We also want to see theatre, dance, live music, cinemas, and other entertainments open to the public.

“But the public health must come first.

Getting beyond the COVID-19 pandemic is bigger than rugby league - it is about the safety of all Australians.”

The English Premier League (EPL) has indicated that crowds may not be permitted at all during 2020.

The EPL’s Chief Medical Officer, Dr Mark Gillett, in consultation with Public Health England, said that social distancing rules are likely to be in place for 6-12 months.

Although the Germany Bundesliga has resumed without crowds, the chair of FIFA’s medical committee, Michel D’Hooghe, believes football should not be resuming until September because of the coronavirus pandemic.

France, The Netherlands, Belgium, and Argentina have already announced that their 2019-20 football seasons will not continue.

26 May 2020

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"Value Our Veterans"

http://anzacportal.dva.gov.au/veterans/stories/Audacity: Henry Stokes

Coolness and courage: ieutenant Commander Henry Stoker

Searchlights swept over the surface of the sea water and the crew fell nervously silent.

Captain Henry Stoker slowly guided the submerged AE2 through the narrow Dardanelles.

Rows of mines bobbed on the surface of the water, and the heavy chains which held them in place rattled against the hull as the submarine passed. The lives of the crew were in Henry's hands. One wrong move could be deadly.

Henry Hugh Gordon Dacre Stoker was born in Dublin, Ireland on 2 February 1885. At the age of 12, Henry surprised his family when he announced he wanted to join the navy. Three years later he was accepted as a naval recruit.

He went on to study at the Naval College in Greenwich, England, and as a young lieutenant took command of the Royal Australian Navy's new submarine, the AE2.

In 1914 he successfully sailed the submarine to Australia. The AE2 and its sister submarine the AE1 were the first submarines to have travelled such a distance.

With the outbreak of the First World War in 1914, the AE2 took part in a mission to German New Guinea, then set off back to Europe to patrol the entrance to the Dardanelles. Attempts by British and French battleships and submarines to get through the Dardanelles had been unsuccessful, with the loss of several hundred men.

Yet Lieutenant Commander Stoker was convinced he could succeed.

At 2.30 am on 25 April 1915, just before the dawn landings on Gallipoli, Henry and the AE2 set out through the Dardanelles. They planned to travel on the surface as far as possible to save the limited power of the sub's batteries, and then dive below the surface at daylight to avoid being spotted.

For two hours, everything went to plan. Then, suddenly, searchlights found the submarine and it was forced to dive.

Henry in England before his voyage to Australia, February 1914.
AWM P01075.045 (detail)

With just a compass, watch and limited use of his periscope, Henry had to navigate through the Turkish minefields.

One crew member reported hearing 18 mine chains scrape the side of the submarine during their journey and twice something louder hit the side, possibly mines that failed to explode.

Despite running aground and narrowly escaping further enemy attacks, Henry's crew slowly guided the submarine further into the Dardanelles.

The crew faced a long, tense day together, sitting in darkness and silence. When they finally surfaced, the cabin stank of diesel fumes and stale air.

The crew took turns standing on the deck, breathing in the fresh night air.

Continued next month