RDMA

RDMA & NLMA's Joint Newsletter

Newsletter

MARCH 2015

See Where We Work & Live on page 20

Solar Eclipse 20/03/2015

In all parts of the UK, the solar eclipse reached at least 83%, with the darkness peaking at about 09:35 GMT. The precise timing and degree of the eclipse varied with location. For the Shetland Islands, the eclipse was at its height at 09:43 GMT and was very near total, with 97% of the Sun's disc obscured by the Moon. For those caught under cloudy skies, the internet was a good option to see the eclipse. Scientific agencies had planes and even satellites gathering video to relay on the web and on television.People keen to catch a glimpse of the rare phenomenon were advised not to look directly at it. Looking directly at the Sun can cause serious harm, and skywatchers were directed to the multiple ways to catch an eclipse safely and in comfort.

A total lunar eclipse will follow on April 4, 2015, visible over Australia, Pacific coast of Asia and North America. Continued page 20

President's Report Dr Kimberley Bondeson

Welcome to cyclone season

This year we have several, starting with Cyclone Marcia, which was a category 5 cyclone that crossed the coast at Yeppoon, Cyclone Nathan, which terrorised the Western Australia Coastline, Cyclone Pam which has hit Vanuatu as a Category 5, and Cyclone Nathan, which is hanging around the Far North Queensland, and hopefully heading out to sea.

With cyclonic weather hitting Australia and other parts of the world, I wonder if there is a correlation between politicians and their policies (or lack of), and the weather?

Or are we simply continuing with a chaotic government? At least federally, the current Health Minister appears to be listening to the doctors and the public.

What we know about the changes to Medicare is as follows, according to the most up to date Australian Doctor edition:

Rebate Cut:

- The $5 cut to rebates for GP attendance items is gone.
- The freeze in indexation of MBS items is still in place and is expected to be there until 2018.

Now whilst this freeze in indexation of MBS items may save the Government money, it could well strangle private practice for both general practitioners and specialists and also affect the public hospital system, which also relies on Medicare rebates from its bulk billing clinics.

Again, have the full consequences being thought through? This is unlikely from my point of view.

Future of Medicare:
It is uncertain if there is going to be any Medicare Reform, or in what format it will be. One thing we do know, is that the Medicare Rule Book is "about 30 years out of date" Australian Doctor, March 2015.

It appears that the Federal Health Minister, Sussan Ley, is considering Direct Billing, which was consistently raised by GP's across the country, including our recent RDMA and NLMA meeting with Minister Ley.

The concern of course, is that this may come with other strings attached, and not just the freeze in indexation of MBS items. We will wait and watch.

Dr Kimberley Bondeson
B.Sc(Hons). MBBS, FRACGP, DAME.

President
Redcliffe and District Local Medical Association.

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RDMA & NLMA's Joint Newsletter
WELCOME FROM

Dr 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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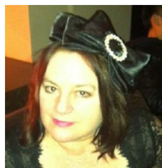

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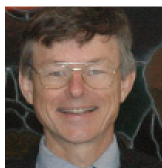

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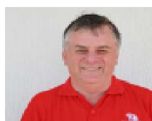

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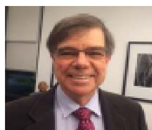

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RDMA 2015 MEETING DATES:

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Meeting Convener: Phone: (07) 3049 4444

CPD POINTS & ATTENDANCE CERTIFICATE AVAILABLE

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Tuesday February 24th
Next ▶ Wednesday March 25th
Tuesday April 28th
Wednesday May 27th
Tuesday June 30th
Tuesday July 28th
Wednesday August 26th AGM:
Tuesday September 15th
Wednesday October 28th
NETWORKING:
Friday December 4th

RDMA NEWSLETTER DEADLINE

Advertising & Contribution is 15th April 2015
Email RDMAnews@gmail.com
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NLMA 2015 Bi-MEETING DATES:

For all Northside LMA Meeting & Membership queries contact:
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Phone: (07) 3121 4565, Fax: (07) 3121 4972
Email: lucy.smith@qml.com.au
Website and Link:
Northside Local Medical Association Website
Link: http://northsidelocalmedical.wordpress.com/

Meeting Times: 6.45 pm for 7.15 pm

1	10th February 2015	2	14th April 2015
3	9th June 2015	4	11th August 2015
5	13th October 2015	6	8th December 2015

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Classified Ad

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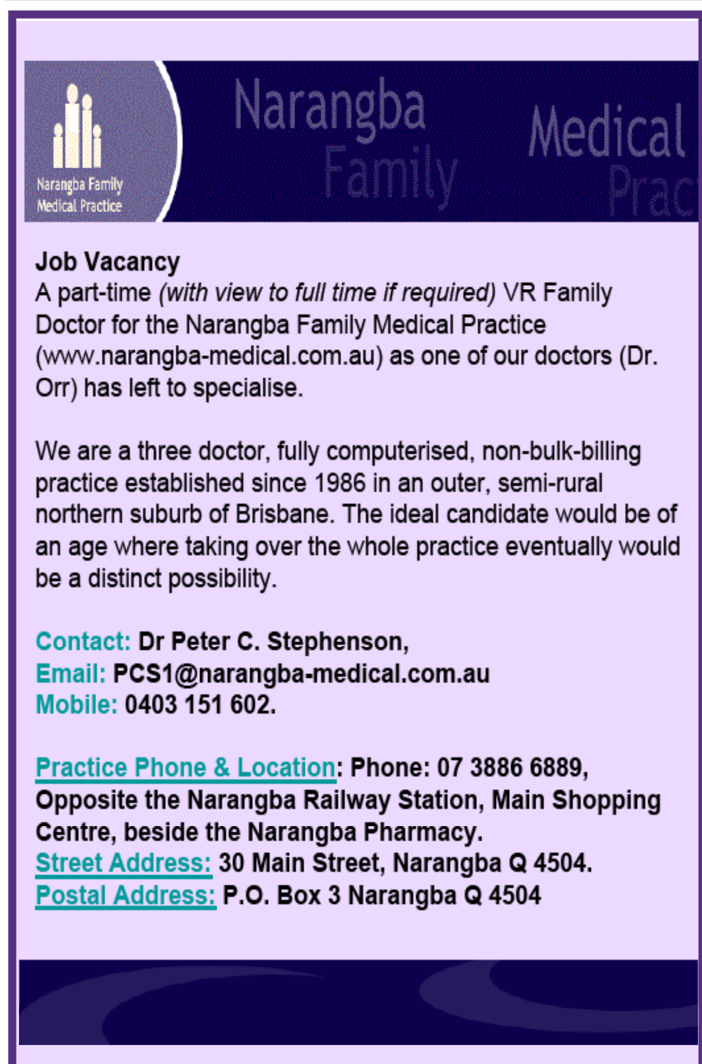
Feb, Mar, Apr 15



AUSTRALIAN MEDICAL ASSOCIATION QLD PRESIDENT
Dr Shaun Rudd

Members' Update

Dear Members,
I'm sure by now you are all aware of the Federal Government's decision to scrap the GP co-payment. This decision comes after 10 months of consultation with AMA and other key stakeholders who recognised the threat the co-payment would pose to the accessibility of healthcare in Queensland as well as the viability of General Practice.

Unfortunately, the Government still plans to go ahead with MBS rebate freezes until 2018. At a time where inflation continues to rise, this would make it challenging for many general practices to continue bulk billing.

AMA and AMA Queensland remain committed to Government consultation and will continue to advocate for the reversal of this freeze.

Locally, Government has just recently announced plans to strengthen vaccination rates across Queensland by allowing childcare centres to choose whether or not to admit unvaccinated children.

It is early days with Health Minister Cameron Dick noting there needs to be more consultation with stakeholders before any legislation can be developed.

AMA Queensland has always supported measures to boost immunisation rates provided these are educative and not punitive in nature. We have long supported the idea of "no form, no play" as opposed to the catchier "no jab, no play."

Many parents of unvaccinated children are not conscientious objectors, rather they haven't immunised their children due to unawareness, inaccessibility or because they just haven't gotten around to it.

Rules that require documentation of conscientious objection or immunisation records are effective because they serve as a checkpoint to ensure every parent has spoken to their doctor about immunisation and that parents are aware of the risks of being unvaccinated.

We hope to be part of the consultation process with Government and will provide members with updates on what new legislation will mean for them.

With the year in full swing, the AMA Queensland Events Calendar is rapidly filling up. After a highly successful inaugural Junior Doctor Conference in 2014, it's hard to believe the next one is now upon us. Abstracts are now open for our Research and "Best moment in medicine" presentations.

These presentations offer junior doctors and medical students the opportunity to share their experiences, ideas and findings with their peers as well as offering invaluable public speaking experience they may not have otherwise had.

I encourage all junior doctors to consider submitting an abstract and hope senior doctors will also encourage their younger colleagues to participate in this great career-building opportunity.

The abstract submission guidelines are available on www.amaq.com.au or can be obtained by contacting our membership team on 07 3872 2222 or emailing membership@amaq.com.au.

The Junior Doctor Conference is just one of the tailored member events that we offer, and we received great feedback last year. We are always interested in how we can expand our event offerings to better suit the needs of members.

Please don't hesitate to contact our team if you have any feedback about events you would like to see.

Sincerely,
Dr Shaun Rudd,
AMA Queensland President

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

Pharmacists Are Still Wanna Be Doctors & Homeopathy is a Sham.

The eternal bunfight between pharmacists and doctors re-emerges every so often. The latest battle mounted by the Pharmacy Guild has been characterized by the AMA as no more than a tactical ploy to strengthen its bargaining position ahead of the negotiations for the 6th Community Pharmacy Agreement. But it creates an unnecessary distraction from the core business of two professions, and creates even more tension between two professions that should be working in close cooperation for the benefit of the patients we have in common. This time, the Guild is negotiating with government to seize primary care funding for cholesterol and blood pressure checks, vaccinations, and primary care consultations for lesser ailments.

The AMA has a problem that the Guild membership, already a major recipient of government funding and far more capable than GP's of expanding their incomes with retail sales, should be laying claim to a share of the limited dollars available for primary care physicians. GP's have already been attacked by revisions (I can't call them "reforms") of Medicare rebates, one change repulsed but two more gathering force on our flanks. At a time when we are seriously considering our financial positions in the face of government policy changes, our erstwhile friends the pharmacists are trying to take even more cream off a cake that has not had any cream on it for years.

And we are profoundly troubled by the concept that a pharmacist, with limited clinical training and experience, might take on a role of primary care diagnosis and treatment. We GP's know how much skill and experience and art are invoked when we try to separate the wheat of important diagnoses from the chaff of trivial conditions. Any tort lawyer will attest to our error rate at performing this difficult task. Will a pharmacist do so as reliably as we can? Stephen Duckett, never a friend of the medical profession, believes that they can, and should be able to charge a Medicare-refundable fee. Will a pharmacist's indemnity fund mop up after the occasional disaster? And, with all due respect to the integrity of our pharmacy colleagues, there remains the question of conflict when the prescriber has a financial interest in the dispensing as well.

The quick bucks from OTC or self-prescribed medications have not escaped the attention of the Pharmacy Guild. They are jealously eying off the New Zealand experience where many drugs are available OTC, including trimethoprim, triptans for migraine, Viagra, antiviral antibiotics, and flu vaccines. New Zealand is a different country from Australia, and their attitude to self-prescribed medications is more in tune with third-world countries than with OECD best practice. We have successfully repulsed suggestions that pharmacists might prescribe statins.

Unfortunately, our claims that a prescription should be preceded by a clinical assessment have been dealt a blow by the advent of internet prescribing. An English company has established internet prescribing – by real doctors and for a small fee – of a limited range of products, currently confined to OCP's, ED drugs, and hair loss drugs. Patients do complete a questionnaire (which I have not sighted) so there is a basic clinical assessment by a doctor.

The company plans to extend the range of drugs available (their UK operation extends to anti-hypertensives, lipid-lowering agents, and asthma drugs). Internet prescribing, if widely supported by the profession, will raise the question about just how much clinical input and exercise of judgment are really necessary before writing prescriptions. Or in other words, how much of the prescribing process needs a doctor and how much can be delegated to a pharmacist.

The latest disingenuous proposals from the Guild come on top of suggestions that pharmacies might commence coeliac disease screening, a task that challenges gastroenterologists. I hope we have seen the end of the heel-sonography testing to diagnose osteoporosis. But we have not seen the end to calls for OTC prescribing of oral contraceptives (except that the imagination stalls at wondering if pharmacies are going to be managing Pap smear protocols and coagulation assessments as part of the OTC prescribing).

The debate about vaccinations will re-emerge next month when the flu

Cont: Page 6

vaccine programme arrives. Flu vaccines are relatively harmless, but we still firmly hold that vaccination is a job for real clinicians with suitable training and backup mechanisms, we bemoan the fragmentation of care and discontinuity of medical records, and we fear the inevitable wedge that accepting flu vaccination by pharmacies will open the floodgates to entitlement to administer more toxic vaccinations. And childhood vaccinations are the trigger to a whole battery of well-child checks. Somewhere there is a line in the sand where the role is indisputably the role of a doctor and nurse. We must maintain that line somewhere on the side that insists that vaccinations are the province of real doctors.

SpotCheck is a programme destined for the scrapheap. This pharmacy-based skin cancer check relies on photographs of lesions taken by pharmacy staff and sent to a doctor for diagnosis. For the doctors in my readership, I do not need to say anything more.

Pharmacists have a valuable role to play in primary care. They have knowledge and skills and experience that GP's do not possess. Home Medication Reviews demonstrate the separation of our respective skillsets and our capacity to enjoin those skillsets effectively. At an individual level, most GP's work quite cooperatively with their local pharmacists. At an industry level, that cooperation repeatedly breaks down. And it is transparent that the reason for the breakdown is a desire by the pharmacy profession to grab more of the taxpayer dollars. To their credit, that greed is not shared by the rank-and-file membership of the pharmacy profession.

Remember that pharmacists won the right to issue sickness certificates, but very few accepted that liability, even for the thirty pieces of silver that came with it. Individually, most pharmacists accept their limitations and would be quite happy to work hand in glove with us in a GP-led team care arrangement. That is the path for the future that we need to map out for government policy.

NEW STATE HEALTH MINISTER

Cameron Dick has been sworn in as our new Minister for Health and Minister for Ambulance Services. I suppose that new-Premier Palaszczuk did not have a lot to choose from, but my immediate gut feeling is not a happy one. We have a lawyer who has served as Minister for Industrial Relations and as Attorney-General but has never held a health-related portfolio or shadow position, and represents a disadvantaged electorate based on Woodridge. The closest that his bio comes to disclosing any real knowledge of health is that his mother was a nurse.

In his inaugural speech in 2009 (yes, he hasn't been in Parliament all that long), he spoke straight from the Labor heart, and lauded the strong Labor values of that remarkable ALP Premier, T.J. Ryan, who he adopts as a role model: "Ryan believed in fairness and equity; in social, economic and industrial justice. But, most importantly, he believed to his core in the never-ending and always necessary need for reform and progress. These are Queensland values. They are enduring Labor values. And they will guide me during my period of service in this House." Pardon my paranoia, but I fear those words "reform and progress" coming from a lawyer with no practical knowledge of a health system. When I was a law student, the Dean of the Faculty told my class that many of us would never be employed as lawyers, but would be snapped up by business because of our analytical skills. Let us hope that our new Minister will be guided by his objective analytical skills more than by blind Labor ideology.

HOMEOPATHY IS A SHAM

Anybody who fritters away idle hours surfing the net will repeatedly come across ever-new examples of political correctness gone mad. The latest to catch my attention was the evidence-based science that proved that homeopathy is a sham. It is remarkable that this study consumed $2M to prove a negative, examining a field that has no science behind it at all. It is even more remarkable that the head of the study said (I quote Six Minutes, a perspicacious digest if ever there was one). Professor Paul Glasziou, who chaired the NHMRC Homeopathy Working Committee, said he hoped the finding would prompt those in the homeopathy industry to think long and hard about whether what they offered was ethical.

This is remarkable because, having debunked a major consumer of wasted health dollars, even Prof Glasziou is still reluctant to call it for what it is. Is that political correctness still pervading a scientific report, or does he fear litigation despite having the truth on his side? We struggled forever to have warnings put on cigarette packs, we managed to get OTC manufacturers to add warnings: if the pain persists, see your doctor.

Will we ever see the homeopaths and pharmacists, who buy new cars from the proceeds of a gullible and even willing public, add a warning: this product has no scientific basis and should not replace real medical interventions. Veritas liberabit vos. The truth will set you free. But only if we stand up and call the truth what it is.

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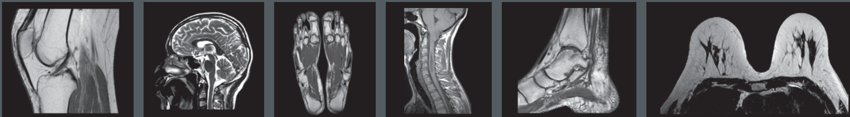

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CADASIL

Clinical history: Previous Stroke, Recurrent Tia's.

Findings

Extensive confluent white matter disease involving the subcortical white matter.

Diagnosis

Findings in a young patient with history of recurrent TIAs and previous stroke are suggestive of CADASIL.

Discussion

Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) is an autosomal dominant vascular dementia, linked to a gene on chromosome 19, which presents with multiple lacunar and subcortical white matter infarctions. There is disproportionate cortical hypometabolism. Presenile dementia and migraines develop in the third-to-fourth decades of life.

Epidemiology

CADASIL is an autosomal dominant trait, with patients typically becoming symptomatic in adulthood (30-50 years of age).

Clinical presentation

Presentation is usually with recurrent transient ischaemic attacks (TIAs) or strokes in multiple vascular territories, and eventual dementia. Clinically CADASIL often has a similar presentation as migraines and may also have auras. Depression, psychosis, pseudobulbar palsy and focal neurological defects are also seen.

Pathology

CADASIL results from a mutation on chromosome 19q12 involving the Notch 3 gene, and as the name implies is inherited as an autosomal dominant trait.

Histology

An angiopathy of small and middle sized arteries is characteristic, without atherosclerosis or amyloid deposition. Diagnosis requires genetic identification of the mutated gene.

Radiographic features

CT

CT is non-specific, demonstrating white matter regions of low attenuation.

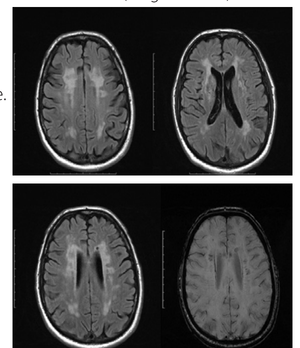
MRI

MRI is the investigation of choice, often demonstrating widespread confluent white matter hyperintensities . More circumscribed hyperintense lesions are also seen in the basal ganglia, thalamus and pons.

Although the subcortical white matter can be diffusely involved, the frontal (93%) and temporal (86%) lobes and subinsular white matter (93%) are classical.

There is relative sparing of the occipital and orbitofrontal subcortical white matter, U-fibers and cortex.

Cerebral microhaemorrhages have been reported to occur in ~45% (range 25-70%) of cases without a characteristic distribution.



Treatment and prognosis

Typically the disease has a variable but progressive course leading to death between 50-70 years of age.

Differential diagnosis

General imaging differential considerations include

- multiple early age infarcts from a hypercoagulable state
- MELAS
- primary angiitis
- subcortical arteriosclerotic encephalopathy (SAE)
- Susac syndrome

REFERENCES
http://radiopaedia.org/articles/cadasil

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AMAQ BRANCH COUNCILLOR REPORT GREATER BRISBANE AREA

Dr KIMBERLEY BONDESON

Medicare Updates and the New Labor Government

Well, the people have spoken, and we have a new State Government. I have to admit, I am just getting my head around the Federal Ministers, in particular the new Federal Health Minister, Susan Ley, who true to her word, is consulting with the medical profession. RDMA and NLMA were invited to a meeting, and we spoke as a group about co-payments and issues affecting General Practice. This was as a direct result of the previous Federal Health Ministe's attempt to introduce by regulation, which would then have needed to be passed by the Senate, a change in the Medicare item descriptor, that was to be have been introduced on the 19th January, 2015. It was put on the Medicare Website in mid-December, 2014, without any consultation with the medical profession. It caused a lot of distress to General Practitioners, their staff and patients. I felt, personally as a General Practitioner, supported by my patients, who came to me, (to my surprise), in droves to ask what they could do. Many had already written to the local politicians and voiced their concerns, without any prompting from myself or my staff. The level of knowledge about what was happening and the implications for patients and the practice itself had been figured out by my patients. One of my 96yo patients told me he had personally rang up and complained to the local member, Luke Howarth.

I attended the Gold Coast Rally on the 16th January, 2015, and was again surprised by the knowledge and response of the General Practitioners and their staff, both nursing and reception, who attended. This particular group did not feel as supported by their patients as I had been. This particular meeting had been planned, at that time, thinking that the item number description change was being introduced on Monday morning the 19th January, 2015. Of course, as we know, it was reversed on the morning of Friday the 16th January, 2015 by the new Federal Health Minister, who said that "due to confusion", it was cancelled. My patients were not confused. When this "backflip" was announced on the Friday morning I was in consultation with a patient. When I came out of the consultation room, my nurse was waiting to tell me. It has come over the radio, and my entire waiting room of patients had clapped and cheered.

I also attended the Rally in Brisbane on Sunday 8th February, 2015. This date had been picked as it was the day before the Federal Senate was due to sit. This group of doctors, both General Practitioners and specialists, were extremely up to date on what had happened, and the ongoing proposed changes to Medicare. Dr Brian Owler, Federal AMA president, gave an excellent speech on what was going on. He said that in his 9 month term as AMA Federal President, he was predominately dealing with General Practice issues. And it would be ongoing, with the current Medicare Rebate freeze being, he felt, of even more significant an issue than the one which had just been reversed. He would continue to fight the Government on these issues.

All the doctors, both General Practitioners and Specialists, have spoken with consistency on the issue of co-payments and Medicare. Let us hope that the government listens.

We have a new State Premier, Annastacia Palaszczuk, who has declared she is committed to restoring frontline health services. We also have a new State Health Minister, Cameron Dick, who has promised 4,400 new nursing positions in Queensland Health. He has also stated that the Labor Government will legislate to ensure nurse-to-patient ratios meets the levels recommended by the experts.

It was a shock election outcome for the previous Liberal Premier, Campbell Newman. My own personal feeling was that it was a surprise for the incoming State Labor Government, as they did not have any specific policies, in health or otherwise.

Let us watch with interest, and continue to protect our patients, and be financially able to keep our practice doors open.

Kimberley Bondeson AMAQ Branch Councillor

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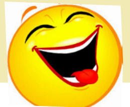
Interesting Tidbits **NATTY MOMENTS:**



Phillis Dillerisms

Whatever you may look like, marry a man your own age. As your beauty fades, so will his eyesight.

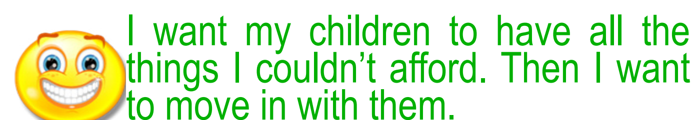
Housework can't kill you, but why take a chance?

Cleaning your house while your kids are still growing up is like shovelling the sidewalk before it stops snowing.

The reason women don't play football is because 11 of them would never wear the same outfit in public.

Best way to get rid of kitchen odour's: Eat out.

A bachelor is a guy who never made the same mistake once.



I want my children to have all the things I couldn't afford. Then I want to move in with them.

Any time three New Yorkers get into a cab without an argument, a bank has just been robbed.

We spend the first twelve months of our children's lives teaching them to walk and talk and the next twelve years telling them to sit down and shut up.

Old age is when the liver spots show through your gloves.

My photographs don't do me justice -they just look like me.

I asked the waiter, 'Is this milk fresh?' He said, 'Lady, three hours ago it was grass.'

The reason the golf pro tells you to keep your head down is so you can't see him laughing.

You know you're old if they have discontinued your blood type.

~~*~*~*~*~*~*~*~*

RDMA February Meeting **24.2.2015 Sponsor: MY IVF**

Chair President Dr Kimberley Bondeson introduced the Guest Speaker Dr John Chenoweth, Topic; Low Cost Fertility Treatment: MyIVF Patient Selection, Preparation and Results Achieved

CLOCKWISE; My IVF Sponsor Representatives Libby Allen, Speaker Dr John Chenoweth and Representative Tom Sexton. Max Chappell and Ron Spermon. Centre Garry Ferris, Michael Cross and Ken Fry. My IVF Sponsor Representatives Libby Allen and Tom Sexton.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: Wednesday 25th March 2015

Time: 7 for 7.30pm

Venue: Renoir Room - The Ox, 330 Oxley Ave, Margate

Cost: Financial members - FREE
Non-financial members $30 payable at the door. (Membership applications available)

Agenda:

7.00pm	Arrival and Registration
7.30pm	Be seated - Entrée served Welcome by Dr Kimberley Bondeson - President RDMA Inc.
7.35pm	Sponsor: Bayer Pharmaceuticals
7.40pm	Speaker: Dr Raluca Fleser Topic: Managing Anticoagulants - from a Haematology perspective.
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 20th March 2015

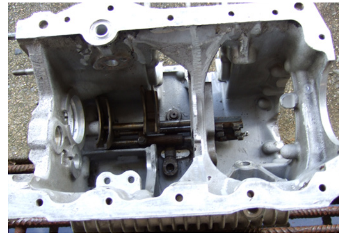
MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #117
Safe motoring,
doctorclivefraser@hotmail.com.

"Mini Cooper S Restoration" (Part 2)

Last month's column took us through the arduous process of resuscitating a middle-aged car, a 1970 Mini Cooper S to be precise.

We got as far as stripping it back to its skeleton and renewing the bodywork to as new condition. By now the Mini was looking great on the outside, but the mechanical restoration was the next step.



Ask anyone and they'll tell you that Minis are difficult to work on. There was an array of special tools to reach into those hard to get to spaces. That compact design left no room to move and a few design flaws that were inherent in a small car that was under 10 feet in length. For starters the original Mini used an existing British Motor Company engine.

Mounted transversely (or East-West) meant that the radiator and fan sat on the right side of the engine bay. The fan blades were reversed and that meant that only hot air from the engine bay was pushed across the radiator. Not exactly an ideal arrangement for dissipating heat from a cramped engine compartment. The distributor sat in front of the engine just behind the grille.

In early models the electricals were completely unprotected from water splashing into the engine bay and Minis were notorious for stopping because of a wet ignition even after simply washing your car. Uniquely, the Mini engine and gearbox shared the same sump (ie lubrication). This could lead to some interesting noises if metal sheared off a gear and found its way into the delicate engine bearings. An oil filter and a magnetised sump plug would help to pick up any metallic debris, but engines and gearboxes were never really meant to use the same lubricant.

The plethora of front wheel drive cars that followed the Mini wisely avoided this configuration to increase the service life of both the engine and the gearbox. But in the Mini this design was arguably as compact as possible. On the plus side the drive shafts were very similar in length as the differential was centrally situated behind the gearbox/engine.

This meant that normally configured Minis didn't suffer the torque steer of later front wheel drive cars with asymmetric drive shafts of unequal length or diameter. The Mini's previous owner had said that "the motor needed a tune-up", but closer inspection revealed that the head was cracked and a new one could be sourced. A new set of piston rings for the 1275cc engine was an affordable $80, but the rings are brittle and unfortunately the last ring to be installed broke meaning another set for another $80.

The internet is a marvellous thing and all the parts seemed to be readily available and surprisingly affordable. Just to be sure that everything would be right my friend replaced the gearbox cluster gear set. Even a meticulous inspection of this part might not identify a tiny amount of wear that would make the transmission noisy.

My friend wanted to be sure that everything worked like new and his attention to detail and hand-crafting of everything was leaving me thinking that his car would be better than the original.

But after 45 years of driving there was always the possibility that something would be missed and my friend might only find out about that problem once he had the Mini Cooper S on the road. To be continued.

Safe motoring, Doctor Clive Fraser

Health Regulation Review

By Dr Wayne Herdy

I want the AMAQCGP to consider asking the President of AMAQ and Branch Council to lobby the new Queensland Government to review one of the Regulations pertaining to prescribing controlled substances in Queensland.

The draft that I want to put before Branch Council is as follows:

PROPOSED REVIEW OF HEALTH REGULATIONS REFERRING TO WRITING OF PRESCRIPTIONS FOR CONTROLLED SUBSTANCES.

The AMAQ seeks a review of the requirement that computer-generated prescriptions for controlled substances be hand-written by the prescriber.
The requirement derives from a regulation:
Health (Drugs and Poisons) Regulations 1996
Section 79. Prescribing controlled drugs.
(5) All particulars on a paper prescription (other than the prescriber's name, professional qualifications and address) must be handwritten.
(6) However, a paper prescription may be generated—
(a) by a computer if the way the prescription is generated complies with appendix 4 of this regulation.

Appendix 4. Computer-generated paper prescriptions:

(5) System messages
The computer program must generate a message that tells the prescriber that the prescriber must write the particulars mentioned in section 79(4)(e) to (n) on the prescription form in ink.

(6) Particulars in a paper prescription that a computer may generate
The particulars mentioned in section 79(4)(b), (c) and (d) may, for a computer-generated paper prescription for a controlled drug, be generated by the computer.

Section 79 states that the computer-generated prescription is an alternative to the hand-written prescription, ie that section does not appear to require a hand-written endorsement.

Appendix 4 requires that the prescriber must write the particulars in ink. It does not state that the particulars must be hand-written, although that has been the usual interpretation. It is a convention of statutory interpretation that the term "writing" and its derivatives include writing by a computer. Nowhere else is that taken to imply the need for hand writing in addition to the computer writing.

Despite this ambiguity of interpretation, Queensland Health believes that the regulation requires prescribers to re-write the prescription in their own hand.

AMAQ argues that the requirement for additional re-writing of the prescription by hand is unnecessary and should be ceased:

(a) The requirement for hand-writing is archaic and anachronistic. The regulation is almost two decades old and derives from a time when computer-generated prescriptions were a novelty.

(b) It derives from a time when all prescriptions were hand-written and fraud could be detected by a pharmacist who knew the prescriber's handwriting. Since few prescriptions are now hand-written and many patients travel further away from the prescriber to have their prescriptions dispensed, it is now much less likely that an individual pharmacist will recognize the handwriting of an individual prescriber. It is therefore unlikely that the addition of hand writing will reduce the rate of fraud.

(c) Fraud is difficult to achieve with computer-generated prescriptions. It is difficult to alter the words or numbers in a way that escapes detection.

(d) It imposes a needless burden on the prescriber. It is an unnecessary duplication of information that has already been written in a clear and legible format by the computer.

(e) There is no evidence that the additional requirement for a hand-written endorsement reduces the rate of fraud.

(f) This regulation will need to be repealed in order to permit chart-based prescribing in nursing homes and electronic transmission of prescriptions.

(g) If chart-based prescribing is introduced in nursing homes, this regulation will either be inapplicable to medication charts in nursing homes, or will make them more complicated and therefore more likely to cause dispensing error.

(h) When electronic transmission of prescriptions from prescribers to pharmacists becomes a practical reality, the need for hand-written endorsements will cease to exist.

The outcome that the AMAQ seeks is an amendment of the regulation to:

(i) delete paragraph (5) of Appendix 4, and
(ii) add a clarifying sentence to paragraph (6) of Appendix 4 to state "It is not necessary to duplicate the details of the prescription in hand writing."

Poole Group
ACCOUNTANTS & INVESTMENT ADVISERS

Income Protection Cover versus Income Protection Plus Cover

What are the differences?

Traditionally, the difference between an insurer's Standard and Plus contracts has been the ancillary/extra benefits. However, over the last decade there have been significant changes in the fundamental definitions of an Income Protection Plus contract that can provide significant flexibility at time of claim over a Standard policy.

For medical professionals it is important to have a Plus contract as the majority of insures will include specific wording and additional lump sum benefits in regards to blood borne diseases, including Hepatitis B, C and HIV.

Disability during the waiting period

In addition to cover for blood borne disease, one of the core fundamental definitions in an Income Protection contract is the requirement to be disabled during the waiting period. Most standard contracts will require the life insured to be totally disabled (not working at all) for a set period of time before they are even eligible for a claim. In a black and white situation, you are either not working at all due to the disability or you are still able to work full time. However, what happens when there is a grey area where you have a disability and you can still work on a part time/reduced basis. If you have a standard contract, the policy would generally not respond until you have been totally off work for the required time which in some insurance contracts can be for 30 days. With a plus contract, the majority of insurers will allow you to continue to work during the waiting period on a part time basis. This has two benefits from the fact that the client will be eligible for an immediate claim following the waiting period and also allows the client to come back and forth from work without any restart of the waiting period or any additional restrictions. This is particularly important for self employed clients so that they can continue to keep an eye on the business without being restricted and/or continue to see patients on a part time basis.

Total and Partial Disability Definition

Some insurers have a standard definition which is usually a "duties" based definition for their total and partial disability benefits. This is opposed to a plus contract where the majority of insurers will provide a three tier definition being an income, hours and/or duties. At time of claim the insured also generally has the choice of which definition out of the three will best suit them. This is particularly important for medical professionals where something like a blood disorder may restrict your actual working duties due to regulatory requirements. Physically you may be still able to perform 100% of your duties but as you are unable to work or can't work in a certain area due to regulatory requirements you have a reduced income. In this situation having a plus contract with a three tier definition provides greater flexibility.

Reductions to the monthly benefit amount

For medical professionals, having a plus contract generally means that at time of claim the monthly benefit will only be reduced if the life insured is receiving payments from any other income protection benefits. Some insurers will provided further flexibility and only offset policies that were not disclosed at time of application. Importantly, the plus contract won't offset any other payments such as sick leave, workers compensation, social security, accident compensation schemes and other statutory insurances payable for loss of income.

Summary

Having a plus contract provides significant benefits over a standard contract which importantly relates to the core fundamental definitions of a policy. The contract will provide a range of ancillary/additional benefits compared to a standard policy but it is the fundamental definitions that make a difference at time of claim between one contract over another.

If you would like to discuss this article please give me a call at Poole Group on 07 54379900.

Article written by Hayden White DFP & Cert IV Finance/Broking

Metro North Maternity GP Alignment Program workshop

Saturday 28 March 2015 - UQ Centre for Clinical Research, Royal Brisbane and Women's Hospital

The six hours of education for the alignment program covers a number of important topics including:

- first trimester presentations
- recommended screening tests
- ultrasound scanning including nuchal translucency recommendations
- diabetes in pregnancy
- prescribing in pregnancy
- communication with Metro North birthing facilities
- models of care options
- Rh negative women
- hypertension
- pre-eclampsia
- early pregnancy bleeding
- reduced fetal movements
- immunisations
- depression
- postnatal care
- breastfeeding

Our presenters include a maternal fetal medicine specialist, general and obstetric physician, staff obstetrician, pharmacologist, physiotherapist, dietician, social worker, midwifery educators, lactation consultant, perinatal mental health nurse, continence nurse advisor, midwives and GPs.

By registering, you agree to participate in the full program, including completion of the 10 Q&A.

RACGP Accreditation

Category 1 QI&CPD Accredited Activity - 40 points

Closely aligned with existing Mater Mothers Hospital and Metro South GP Maternity Shared Care Alignment Program.

Sponsored by

Date

Saturday 28 March 2015

Venue

Auditorium, UQ Centre for Clinical Research, Royal Brisbane and Women's Hospital
Butterfield Street, Herston QLD 4006

Program

9:00am	Optional Tour of Women's and Newborn Services
9:30am	Registration and Morning Tea
10:00am	Workshop (with lunch and afternoon tea breaks)
5:00pm	Workshop concludes

Register online

www.mnbml.com.au/events-health-care-professionals

Registrations will close Wednesday 25 March 2015

Workshop enquiries

Brigid Wheaton
Program Coordinator
Metro North Maternity GP Alignment Program
e mngpalign@health.qld.gov.au
p 07 3646 4421

This is a joint initiative between Metro North Hospital and Health Service and Medicare Local

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REPORT SHOWS THAT GENERAL PRACTICE IS EFFICIENT AND COST EFFECTIVE

The latest report from the National Health Performance Authority (NHPA) shows that general practice is the most efficient and cost effective part of the health system, but requires greater support to continue providing high quality primary health care to the Australian community. AMA President, A/Prof Brian Owler, said today that the NHPA *Healthy Communities: Frequent GP attenders and their use of health services in 2012-13* report provides important data to understand the characteristics and use of health services by people who visit a GP frequently.

The report shows how frequent users of GP services are distributed, and how they differ from other patients in the number of GPs they visit, the cost barriers they face, and their demographic characteristics. The report also provides insight into the degree with which frequent attenders also use other health services, including visiting emergency departments and being admitted to hospital. "This report is further evidence that general practice underpins the Australian health system by providing appropriate specialised care at the appropriate time," A/Prof Owler said.

"It shows that the people who most frequently attend their GP are generally unwell, and have complex and chronic conditions, which include arthritis, osteoporosis, diabetes, cancers, heart conditions, circulatory conditions, asthma, and mental health. "Contrary to what was implied by some in the recent debate over co-payments, these patients are not frivolous users of the health system. These types of patients are consuming significant health resources, and there is a significant need to target these patients with extra support, coordinated by their usual GP. "Patients whose care is well managed and coordinated by their usual GP are less likely to cost the health system more in the long run because their GP-coordinated care will keep them out of hospital.

"Supporting general practice to continue managing these patients – who are growing in number each year – is an investment in health care that can help make the health system more sustainable." A/Prof Owler said the report highlights the importance of patients – especially patients with complex and chronic conditions – to have a regular GP to manage their conditions. "As these types of patients place greater demands on the system, general practice will need greater support. "The AMA is promoting a model of care similar to the Department of Veterans' Affairs (DVA) Coordinated Veterans' Care (CVC) program, which provides pro-active and coordinated health care for patients at serious risk of hospitalisation," A/Prof Owler said.

Key findings:

- Australians see a GP 5.6 times per year on average, but some need to see a GP more frequently;
- 13 per cent of Australians were very high or frequent GP attendees, who accounted for $6.5 billion or 41 per cent of non-hospital Medicare expenditure;
- these patients were more likely than other groups to see many more different GPs. They were also more likely to be older, live in areas with the most socioeconomic disadvantage, and have the lowest rates of private health insurance;
- very high and frequent GP attenders also use more other non-hospital Medicare funded services. Most very high users had at least one pathology episode (93per cent), diagnostic imaging service (77.8 per cent), or specialist attendance (68.4 per cent); These services were accessed at a higher rate than for other GP attender groups.
- on average, very high GP attenders had 6.5 pathology episodes in 2012-13, 4.2 after hours GP attendances, 2.7 chronic disease planning and management services, 4.8 specialist attendances, and 4.1 diagnostic imaging services;
- in 2012-13, 2.5 million (14 per cent) of Australians aged 15 years and over attended an emergency department (ED) in the preceding 12 months;
- very high and frequent GP attenders were more likely to have visited an ED, with 8 per cent of very high GP attenders visiting an ED four or more times;
- 23 per cent of those attending an ED felt their most recent visit to the ED was for care that could have been provided by a GP. Low GP attenders were the most likely to have this view. However, these findings should be interpreted with caution as survey response rates were small in this category;
- 27 per cent of adults reported they delayed or did not see a GP when they needed to. Those most likely to do this because of cost were very high GP attenders (8 per cent, compared to 4 per cent of low GP attenders);
- very high GP attenders (64 per cent) generally rated their health as poor;
- the vast majority of very high (89 per cent) and frequent (84 per cent) GP attenders had one or more long-term health conditions; and
- very high and frequent GP attenders also account for a high proportion of hospital admissions. Taken together, patients in these two groups represented nearly 60 per cent of all adult Australians who reported in 2012/13 that they were admitted to hospital four times or more in the previous year.

19 March 2015

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Odette Visser 02 6270 5412 / 0427 209 753

ITALY - LAKE GARDA

By Cheryl Ryan

Lake Garda, the largest of the Italian lakes, spans the regions of Lombardy on its western shores, Veneto to the east and Trentino at the top of the lake.

Although carved out of the limestone rock by glacial action, the lake lies only 65 metres above sea level and is like a fragment of the Mediterranean transferred to the shadow of the Dolomites. The northern end of the lake has a dramatic, almost fjord-like appearance on the western shoreline, while to the east the mass of Monte Baldo (known as The Garden of Europe) runs down alongside the lake. The southern end of Lake Garda has a flatter, gentler landscape. Nearby is the beautiful city of Verona, made famous as the setting for “Romeo & Juliet”. Verona is second only to Rome for the number of historical monuments found within the city. One of these, L’Arena, built in AD30, is the largest open- air lyrical theatre in the world and famous for its summer opera season.

Climate
It has a mild sunny climate with average temperatures of mid to high twenties from May to September with daily sunshine of 11-12 hours per day.

History
Over the centuries, this region has been under the influence or direct rule of many foreign powers, from Germanic tribes to Napoleon, Italian feudal lords to Spanish kings, and it wasn’t until the end of WW1 and the departure of the Austrians that the region finally came under the control of a unified Italy. Even today the local dialect spoken here has noticeable Spanish and French influence. The lakeside town of Salo’ was set up in 1943 as a Nazi “puppet republic”, where the disgraced Mussolini made his last stand, after fleeing Rome as his fascist state began to collapse. Five hundred years earlier Gasparo Bertolotti was born here. Famous as a maker of stringed instruments, he is regarded as the inventor of the violin.

Local Produce
The eastern shore of Lake Garda has long been known as “the Riviera of Olives” with wide scale commercial olive cultivation.
It is the northern most area in Europe for this and the olive oil from here is known for its light, fruity and non-acidic flavour. The southern end of the lake is home to the wine making areas of Bardolino and Valpolicella, best known for their reds; the light Chiaretto, the rich Amarone, and the sweet Recioto. The northern Trentino area is well known for its distinctive dry whites.

Did you know?
The dramatic opening car chase sequence in the James Bond movie “Quantum of Solace” was filmed through the gallerias and twisting curves of the cliffside road on the northern shores of Lake Garda.

Cassone is the location of the river Aril, officially the “world’s shortest river”, with a length of only 175m.

Punto Veleno - one of the world’s steepest bike races is held in September every year from Castello to Prada. Rises 1080m over a 8km distance. This famous race is open to both MTB and road racing cycles. Red Bull world cliff diving world championships take place from the Castle walls of Malcesine 27m down into the lake.

Cheryl Ryan 123Travelconferences

VIOLENCE & COMMUNICATION

By Dr Mal Mohanlal

There is never a hard and fast rule about bringing up children. It is all boils down to communication, how we communicate with a developing mind. It all has to do with love, care, attention and discipline we give to our children.

Being born is a violent experience. One should consider oneself lucky to be born alive and healthy. It is all about survival and learning afterwards. Remember a child is not born knowledgeable; it has to be taught social values. Parents and also our teachers therefore, have a great responsibility of training and teaching a child how to communicate and relate with the outside world.

This necessarily involves social conditioning. If the parents and teachers do not teach a child how to be responsible for its action and how to be considerate and respect other members of the family and society, we have a recipe for a social disaster.

There is not a day that goes by without some news on unruly youth behaviour and violence. Youth violence is found not only amongst themselves in the form of bullying and physical punch ups but also directed towards other members of society in the form of vandalism and criminal behaviour.

It has reached a stage in society where even the police today are finding it hard to cope. They have to use violence to control them. How did we get to this state? Where have we gone wrong?

Clearly the lack of discipline and training at home is the main cause of our problem. It is negatively influencing our children. Abdication of parental responsibilities by doting parents in this consumer age cannot possibly help this situation where they will side with the child rather than the teacher in matters of discipline. Then with the laws we have, preventing parents and teachers to discipline any child under any circumstance, further compounds the problem by giving these children the impression that the world owes them a living.

Now if parents cannot discipline their children at home and teachers cannot discipline them at school, who is going to teach them any social values? Is it not farcical to note that it is illegal to use 'violence' against children at home and school for disciplinary purposes yet we are forced to use violence against them when they are out of control as teenagers? This is like trying to shut the gate after the horse has bolted. Has this measure achieved any reduction in any violence of any type to date?

I assume that the reason for not using 'violence' against children, besides feeling good about ourselves, was to show the world that we are a civilised society that could raise children without exposing them to violence, and these children who were unexposed to violence would then grow into less violent citizens. Well by abandoning discipline in the home and in the classroom we have really thrown the baby out with the bathwater.

Just look at the cases of domestic violence and abuse increasing in society. Surely with the laws we have with no 'violence' (discipline) against any child, this problem should be decreasing. Don't you think this is directly related to the way we bring up our children without any discipline or consideration for other people?

Whether we like it or not, violence is in our blood and is derived from our territorial and survival instinct. We hate, we fear, so we cannot eliminate violence by just philosophising or legislating against it. It is a form of communication as a last resort, otherwise why do we have to fight wars?

Senseless violence occurs when there is no insight or self-discipline in a person's behaviour. There is no sense of responsibility towards oneself or society. Clearly our law makers have failed us in their duty of care towards parents, teachers and society by formulating laws that encourage irresponsible behaviour.

Consumerism panders to the desires of the individual ego. This leads to distorted perceptions. Distorted perceptions lead to mental ill health and also anti-social behaviour. Since we are the profession dealing with the physical and mental health of people, where do we stand on this issue? Are we just going to standby feeling good about ourselves and let society go to the pot? Should not there be any discipline in the home or in the classroom?

Negative action will produce negative results; positive action will produce positive results. At present we are getting negative results in human behaviour. It means our input in training these young minds is negative. One does not have to be a prophet to predict the future. The future is already here.

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AMA

THE CASE OF THE MISSING HOSPITAL BEDS

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AIHW Report – Admitted patient care 2013-14: Australian hospital statistics

AMA President, A/Prof Brian Owler, said today that the latest report from the Australian Institute of Health and Welfare is a welcome update on the state of Australian hospitals, but the AMA is concerned that this report is lacking data on a key performance indicator – the number of hospital beds.

A/Prof Owler said that the report, Admitted patient care 2013-14: Australian hospital statistics, does not report the number of beds available in public hospitals, a statistic traditionally included in this report.

“The number of beds is key information about the capacity of our hospital system to meet the community’s needs for acute medical care, and it is a mystery why it is missing. The AMA hopes to see bed number statistics in future reports,” A/Prof Owler said.

“The data that is published, however, shows that, of the 9.7 million admissions to hospitals in 2013-14, 5.7 million were in public hospitals and 4 million were in private hospitals.

“There was a modest 3.3 per cent increase in public hospital admissions compared to 2012-13, and a less than 0.1 per cent increase in patient days.

“Given the population grew by more than 1.7 per cent in the same period, these modest increases are barely keeping up with need under current public hospital funding arrangements.

“In contrast, private hospital admissions grew faster.

“On top of the missing bed numbers, the report does not provide forecasts about the future facing our public hospitals under the Commonwealth Government’s reductions to overall public hospital funding.

“Commonwealth funding was reduced in the 2014-15 Budget, and then further reduced in last December’s MYEFO.

“While there is a year-on-year funding increase, the amount of that increase is reducing at each Budget update. It is not keeping pace with increased demand, and is clearly inadequate to achieve the capacity needed.

“The Commonwealth has flagged that, from 2017-18, it will unilaterally change the basis for setting its contribution to future public hospital funding to indexation and population growth.

“This will create a totally inadequate base from which to index future funding for public hospitals.”

19 March 2015

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REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

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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.

Annual subscription is $100.00. Doctors-in-training and retired doctors are invited to join at no cost. 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/ or speakers are most welcome.

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

ABN 88 637 858 491

1. **One Member (July to June: $100; Oct.-June: $75; Jan-June: $50.00; April-June: $25.00)**
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Practice Address: ______________________________ Post Code: ________

Phone: ______________________ Fax: ______________________

CBA BANK DETAILS: **Redcliffe & District Local Medical Assoc Inc:BSB**: **064 122 Account**: **0090 2422**

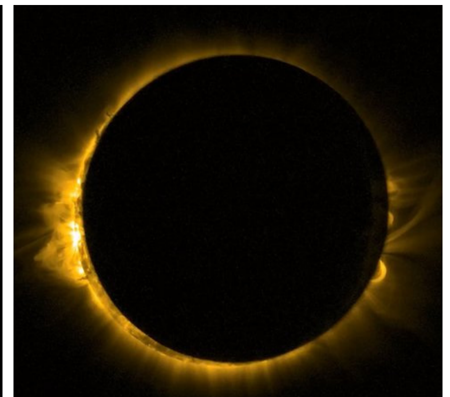
METHODS OF PAYMENT:

1. **PREFERRED INTERNET BANKING**
2. **PAYMENT BY DEPOSIT SLIP**: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. **ENCLOSED PAYMENT:** (Member Subscription Form on website, type directly into it and email)
   i) **Complete form & return:**
   - **c/-QML or Redcliffe & District Medical Assoc Inc. P O Box 223 Redcliffe 4020**

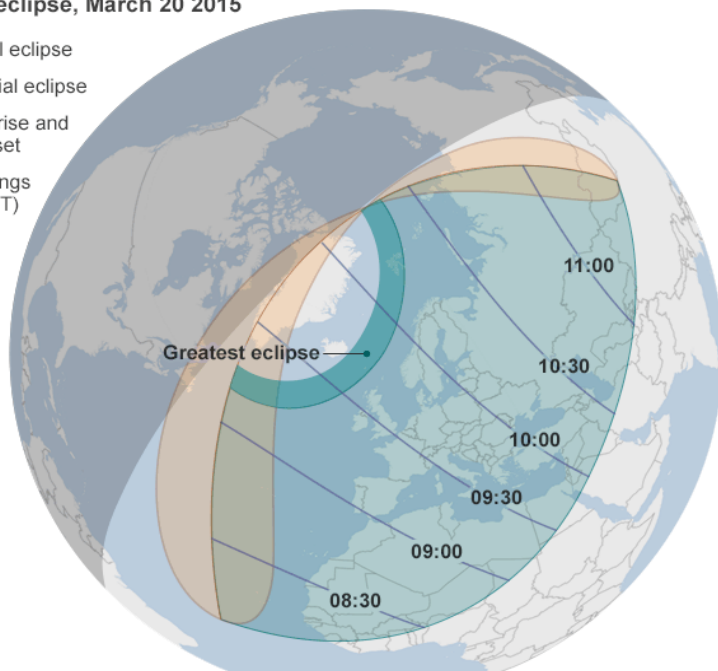
   ii) **Or by email to GJS2@Narangba-Medical.com.au**

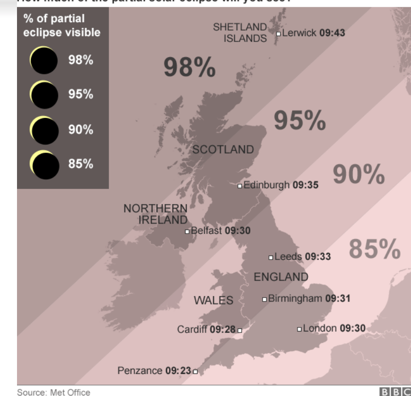
Where We Work And Live

Millions of people across the UK and northern Europe have gathered to see the best solar eclipse in years. A path across the Earth's surface was plunged into darkness when the Moon covered up the Sun. From an aeroplane above the Faroe Islands, a BBC camera crew captured startling footage of the event reaching totality at 09:41 GMT. The Faroe Islands and Svalbard in the Arctic Circle were the only places to experience a total eclipse. The deep shadow formed first in the North Atlantic and then swept up into the Arctic, ending at the North Pole. In the UK, the weather turned out to be slightly better than anticipated, with clouds breaking in many places at just the right time. London and the South East, on the other hand, just saw their grey day get slightly gloomier. Footage revealed interesting features of the eclipse, including a clear view of "Baily's beads". These



Solar Eclipse 20th March 2015





are the sparkles of light seen at the very edge of the Moon, where its rugged landscape allows the last rays of sunlight to peak through before full obscuration.
Few land areas were directly in the path of the Moon's deepest shadow - its so-called umbra - and seabirds probably had some of the most dramatic eclipse experiences. The period of greatest darkness - nearly three minutes - occurred over a spot in the Norwegian Sea, a little below the Arctic Circle, at 09:46 GMT. The team hoped the observations could help them improve future weather forecasting capability.
Study leader Prof Giles Harrison said: "Early analysis of the data shows some wonderful results, thanks to some excellent observations by our army of citizen scientists. "Along with a rapid drop in temperature, there seems to have been a reduction of cloud cover around central England, parting the clouds momentarily for some viewers. "We will be analysing the results in more detail over the next few weeks to see if we can discover any other effects."
http://www.bbc.com/news/in-pictures-31981666