REDCLIFFE & DISTRICT and BRISBANE LOCAL MEDICAL ASSOCIATION

RDMA & BLMA's Joint Newsletter

Newsletter
MARCH 2019

"Bravery Under Fire: Sister Claire Trestrail"
Audacity: Stories of heroic Australians in wartime.
Website: www.dva.gov.au

See Where We Work & Live
P20. Bravery Under Fire:
Sister Claire Trestrail

RDMA President's Report Dr Kimberley Bondeson

We are now in autumn, and having unusually hot days – up to 36 degrees on the Redcliffe Peninsular, with the occasional hail storm, whilst Sydney is experiencing wild storms and large hail stones. Further down the coast of Australia, they are experiencing uncontrollable bush fires. And this morning, a new cyclone is predicted to drop a large amount of rain on Townsville (again!).

The RACGP is getting itself into potentially murky waters, by entering into a three year agreement to promote General Practitioners software called Hello Health. The College also sets the eHealth Standards for GP practices. To me, this seems an outright conflict of interest.

Opioid prescribing is again on the agenda, with GP's being targeted by the HIC over their opioid prescriptions, some of these General Practitioners targeted, are doing a large amount of Palliative Care and Aged Care servicing.

According to NEWS GP, 14th March 2019, the letter from the Department of Health stated that "The GP is been told they must now reduce their prescribing within 6 months or risk potentially career threatening consequences under a Professional Services Review". The Department of Health has made a statement that the RACGP and AMA and other professional bodies were consulted on the design of the letters.

Sound like the Department of Health is making a mess, and the Palliative Care and Aged Care patients are the patients who are going to suffer. One Doctor I know received such a letter, and had not prescribed any significant opioid medications for several years. Yet the letter stated that this doctor's prescribing was above the normal GP level. When we checked this doctor's opioid prescriptions on our practice software, some of the other GP's patients' names in the practice came up, as if this doctor had prescribed them opioids, and yet the GP in question had never seen those patients.

The outcome of the Department of Health letters can be seen as interference in the clinical care of palliative and aged care patients. It will stop younger GP's from taking on palliative care patients, or aged care patients. It will force GP's to send patients who have been discharged on opioids by hospitals back to those hospitals for further opioid prescriptions.

Already, in my practice, we are refusing to take on any new patients who are on opioids or other addictive medications. On occasion and on further questioning, we find that we are often the 5th practice these patients have approached looking for opioid or BZ medications, particularly if they are new to the area. These doctor visits, which have not resulted in an opioid or BZ prescription, do not come up on the Doctor Shopper register, as prescriptions for opioid or BZ's had not been issued.

Our new generation of General Practitioners, Palliative Care Doctors and Aged Care Doctors, are going to require ongoing support by their senior colleagues, in terms of allowing them to feel confident in prescribing appropriate opioid and benzodiazepine medications to patients who need them.

Presidents Report, Dr Kimberley Bondeson
March, 2019

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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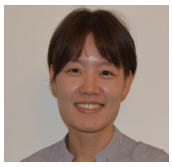

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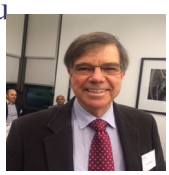

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UPDATED

RDMA 2019 MEETING DATES:

For all queries contact Anna Wozniak or Emelia Hong 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	26th
Tuesday	March	26th
Tuesday	April	23th
Wednesday	May	29th
Tuesday	June	25th
Wednesday	July	31st
ANNUAL GENERAL MEETING - AGM		
Tuesday	August	20th
Wednesday	September	18th
Tuesday	October	29th
NETWORKING MEETING		
Friday	November	29th

NEWSLETTER DEADLINE

Advertising & Contribution 15th March 2019

Email: RDMANews@gmail.com

W: www.redcliffedoctorsmedicalassociation.org

BLMA 2019 MEETING DATES:

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

W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

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

Time: 6.30 pm for 7.00 pm

1	February	12th
2	April	9th
3	June	11th
ANNUAL GENERAL MEETING - AGM		
4	August	13th
5	October	8th
6	December	(10th) TBC

Next Meeting Date 26th March 2019

RDMA February Meeting for 26.02.2019

Dr Kimberley Bondeson RDMA President Introduced the Speaker:

Speaker
Dr Manoy Matthew, Orthopaedic Surgeon,

Topic "Common Shoulder Pathologies, Clinical Examination and Management".

Sponsor: Zimmer Biomet

Photos (Left to Right):

Speaker
Dr Manoy Matthews,

Sponsor Representatives:
Kerra McDonald and Shayne Engelbrecht

New Members Edison Chong, Shayne Ockerby, Nathan Kok and Kasun Wakwella

New Member
Kin Keung Kwong

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 26th March 2019**

TIME: 7pm for 7:30pm start

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

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

AGENDA:

7:00pm	Arrival & Registration
7:30pm	Be seated – Entrée served
	Welcome by Dr Kimberley Bondeson – President RDMA Inc
7:35pm	Sponsors:
	Caboolture Private Hospital
	GenesisCare – Radiation Oncology
	Menarini Australia
7:40pm	Speaker: Dr Rick Abraham – Medical Oncologist
	Speaker: Dr Debra Furniss – Radiation Oncologist
	Topic: Melanoma – Radiotherapy options
	New advances in Targeted Therapy
	Topic: Lung Cancer – Radiotherapy options
	New Advances in Targeted Therapies
8:00pm	Main Meal Served
8:20pm	Question Time
8:40pm	Dessert, Tea & Coffee served/ General Business

RSVP: By Friday 22nd March 2019
(e) RDMA@qml.com.au or 0466 480 315

INSIDE THIS ISSUE:

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- No charge to current RDMA members.
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AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

Does Aged Care Have A Future?

The answer of course is "I certainly hope so", because we all aspire to be there ourselves one day. But what is that future looking like? With the Aged Care Royal Commission in full swing and gaining momentum, Australia is looking to the Commissioners to produce a result that delivers optimal care but affordable and sustainable solutions. As I read the transcripts of the Commission, it looks as if the medical component of aged care is barely a footnote. If the College of GP's and AMA had not surfaced, the reader would almost think that doctors had nothing to do with aged care.

I have mounted my hobby horse and written a 17-page personal submission (which I won't reproduce here, I'll spare you the pain) arguing the doctor's case – which the College and the AMA have not done as thoroughly as they might have. My thesis is basically this – (a) residential aged care in the patient's home is Nirvana but inefficient, costly and impracticable (b) nursing homes are nursing homes, not doctoring homes, but the GP has a central part to play in oversighting the patient's health needs, but (c) there are a hundred good reasons why GP's don't flock to nursing homes and only one good reason why any attend at all, altruism.

About one GP in six attends nursing homes, and about one in 16 has a significant nursing home practice – that sort of figure attests to the desirability of aged care practice. I'm guessing that maybe one GP in 100 has done formal training in palliative care, a skillset that almost every nursing home patient is going to need. When the AMA surveyed the workforce some years back, they identified that the average age of a GP engaged in significant aged care practice was about 58 – half of that GP workforce was going to retire within a decade.

Nursing home practice just doesn't pay as well as office practice. By the time you account for telephone calls and administrative functions like writing scripts for the pharmacies to lose, only about one contact in five attracts a Medicare benefit. And families are lacking in understanding and realistic expectations, adding to the unpaid time burden as well as the aggravation. And the patients are complicated, with multiple morbidities even when you get past the dementia +/- delirium +/-depression, polypharmacy and renal/liver failure, as well as legal/ethical conundrums that plague the end of life decisions.

Now the compassionate and insightful Federal Government has introduced two Medicare measures which they heralded as intended to enhance the quality of medical care in nursing homes. Firstly, they amended the "flagfall" premium on nursing home visits, so that a visit including more than ten or so patients will yield a lower fee per patient. Secondly, they abolished the PIP of up to $5,000. For a GP like myself, who is so mentally disturbed as to carry a workload of 150-odd nursing home patients, starting work in nursing homes at 6.30 three mornings a week, and spending an unpaid 3-4 hours once a week just writing scripts, this yields me a nett income reduction of about $10K a year. I can't quite see the logic of how this increases the quality of existing care in nursing homes, let alone entice the young graduate to choose a career based in aged care.

So, when I hit my dotage and rely on the assisted care of my future nursing home, which bright dedicated young graduate doctor is going to guarantee that I spend my fading years in safety and comfort? I don't see a queue forming to seize that career as a prized objective.

Dr Wayne Herdy

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION
DR GEOFFERY HAWSON'S SECRETARY REPORT

BREAKING NEWS: AMA IGNORES OVERWHELMING MAJORITY VOTE (91%) AT NATIONAL CONFERENCE - MOTION PAGE 7

RDMA members might remember that a survey concerning registration, CPD and transition to retirement was conducted with members from RDMA, Sunshine Coast LMA and Brisbane North LMA in 2017. An overwhelming majority supported a step-down form of registration based on reduced CPD hours, with many believing that doctors should be given the opportunity to continue to contribute to the profession. An incongruity has arisen with the expansion of the scope of practice for some allied health professionals (including prescribing rights) at a time when doctors are being limited not just as they transition to retirement but also during their careers when their roles may change.

As a result of the RDMA survey (see newsletter Feb 2018), a motion was put to the National AMA Conference in May 2018 that a similar survey be conducted by the Federal AMA to ascertain all AMA members' thoughts on these issues. The motion was carried in the affirmative by 91% of the delegates present. See overpage for Motion and Background.

Ten months on, at a recent AMAQ council meeting I enquired as to progress on this survey. The AMAQ President and the Chair of AMAQ Council informed the meeting that the issue was not progressing and advised that I should put a query in to the next Federal Council meeting. In response to this, I sent 1) a query asking why no action had been taken given that the motion had been overwhelmingly supported at the conference, and 2) a proposal for RDMA to conduct the federal survey of AMA members on behalf of the AMA. A budget and timeline were submitted.

I have recently been informed that the motion (page 7) was forwarded to the Medical Practice Committee (MPC) of the Federal AMA late last year. MPC debated the issue and decided not to run a survey as there was "no appetite for the Medical Board to change its position" and because the AMA had previously conducted a similar survey. The MPC's report was discussed at the Federal Council committee meeting on 15 March. Despite strong advocacy by Sean Rudd and our QLD President, Dilip Dhupelia, all states except QLD voted not to support a survey but to have further discussions with the Medical Board about retired doctors at their next meeting. It is not clear what these discussions will entail. As yet, I have not received a formal response from the Federal Secretariat. When I do, I will be requesting details of the previous survey (when conducted, focus of questions, results) to ascertain to what extent the survey covered the issues now of concern to members.

I believe that the AMA has missed a couple of key issues.

1) This debate and our survey were about transition to retirement, changed scope of practice and contribution to the profession before and after retirement. All professions undergo a process of evolution and future medical practice is likely to incorporate a range of forms of practice. The challenge is for regulatory and professional bodies to acknowledge, support and respond to the dynamic nature of these forms. It appears that the Federal AMA is narrowly focusing on retired doctors and registration.

2) There was a clear and massive majority of votes in favor of the motion to have a national survey. The Federal AMA has completely ignored the delegates' vote. This brings in to question the nature of democracy within the AMA and the purpose of national conference voting if Federal Council members can veto any carried motion. The AMA should be acting on behalf of its members not AHPRA and the Medical Board. It is important to document what members consider important to the profession and surveys are a means of doing this.

I will again be attending the National Conference in May as a delegate and will be speaking to a motion to have the Federal AMA act on the vote, and take the opportunity to alert members to the issues during the "Soapbox" session.

The AMA believes the issue is dead. I believe it is not, and it is time for us to ask for some action.

I would appreciate any thoughts on how to progress this issue.

Geoff Hawson, Secretary RMDA

Motion: We move that the federal AMA approves a nationwide survey of members to ascertain their views on limited registration in transition to retirement and retirement, the scope of practice for limited registration, the registration requirements (recency of practice, definition of practice, CPD), and the potential range of practitioner contributions to the profession in transition to retirement and retirement.

Background and context: In 2011 the AMA declined to continue its support of retired doctors' efforts to maintain limited registration and indicated that it would "not continue to advocate for a registration category for retired doctors solely on the basis that these doctors would be writing prescriptions and referrals for themselves, their family and friends" (Pesce, 2011).

Since 2011 the landscape has changed considerably in terms of the scope of practice of a range of health professions. Government initiatives now enable prescribing rights for allied health practitioners and the expansion of the scope of practice for a range of non-medical health practitioners to include medical advice, referrals for MRI (audiologists), and blood profiles (dietitians) (Ministerial Taskforce on health practitioner expanded scope of practice, Queensland, December, 2016). Physiotherapists, for example, have been given rights "to prescribe scheduled medicines for the management of pain in patients presenting with musculoskeletal and/or spinal conditions to emergency departments or specialist outpatients screening clinics" with the Ministerial report documenting that the "initiative supported and enabled trained physiotherapists to provide advice, prescribe or administer from an agreed list of scheduled medicines under a research framework, subsequent to local credentialing and following approval under Section 18 of the Health (Drugs and Poisons) Regulation 1996".

Given the abolition of the Limited Registration Public Interest Occasional Practice (LRPIOP) for retired doctors, and the continuing expansion of scope of practice for allied health professionals, it is timely for the AMA to reconsider and address how senior/retiring doctors can continue to contribute to the profession with their wealth of experience and skills. Indeed Pesce (AMA President, 2011) stated "There are many reasons why doctors of any age, at any time in their lives, may choose to undertake a limited scope of practice. The challenge for the profession now is to be clear about what those limited scopes of practice might be, and what the appropriate registration requirements should be in terms of continuing professional development and medical indemnity insurance…. I welcome your views on how the AMA can shape the future practice of medicine as individuals make choices about how they practise their craft."

Cognisant of these issues, the executive of the Redcliffe and District Medical Association (RDMA) conducted a survey of RDMA, Sunshine Coast LMA, and Northside LMA members (131 respondents) to determine attitudes towards loss of privileges at retirement and the concept of limited or step-down registration. The results (to be reported in the February RDMA newsletter) indicate that the vast majority of survey respondents (88%) agreed that 'limited registration in retirement' should be considered and that referral to specialists (79%), pathology (73%) and radiology (72%), and prescription rights (73% ongoing, 60% new and repeat) should be preserved. That 75% of respondents were yet to retire indicates that these issues resonate with a broader membership than retired doctors. Importantly, respondents acknowledged that 'limited registration' should carry with it maintenance of standards and competency through continuing professional development. Seventy-one percent of respondents were concerned by the loss of registration privileges, with comments indicating a desire to continue contributing expertise and experience alongside a frustration at how this can be achieved. The results suggest that the issues for practitioners are complex and encompass more than "writing prescriptions and referrals for themselves, their family and friends". Professional organisations play a role in supporting their members through a number of transitions and these results suggest that the AMA could play a leadership role in facilitating the transitional process for members.

While retired doctors can maintain full registration by completing the associated requirements of recency of practice, CPD and medical indemnity insurance, there appear to be a number of barriers to retired doctors achieving these. For example, a retired General Practitioner having readily met their recency of practice requirements before retirement may find that accessing direct clinical experience (as their preferred practice under the AHPRA definition of practice) is difficult post-retirement because there are few formal mechanisms to enable this. In other professions mechanisms exist to enable retired professionals to contribute their expertise and maintain practice recency. For example, retired lawyers in Australia are being actively encouraged to take on pro bono work in the community with free practising certificates issued by state law societies as a consequence of advocacy and recommendations contained in the Productivity Commission's Access to Justice Arrangements Inquiry Report (Engaging Retired and Career-Break Lawyers in Pro Bono, National Pro Bono Resource Centre, February 2010; http://www.probonocentre.org.au /apbn/nov-2015/ free-volunteer-practising-certificates-now-available-five-jurisdictions). Similarly, medical practitioners in a transition to retirement or retirement phase could be invited to fulfil the acute pain management role in emergency departments that is now being transferred to physiotherapists (see above). Retired doctors might also be called upon to oversee diabetes management in pharmacies.

Little is known about the extent to which retired, registered doctors participate in unpaid/voluntary work nor whether this work is recorded as fulfilling recency of practice requirements nor whether other retired doctors would welcome these opportunities if offered. Additionally, little discussion has centred on how a step-down approach to registration could be achieved and what this might entail. Nor has the AMA membership been surveyed for their views on issues around recency, definition of practice and CPD requirements in relation to retirement, nor on the possible components of a limited or step-down registration. Little is known about the barriers to meeting registration requirements once retired and whether formal mechanisms and supports (such as LMAs providing assistance in the form of journal clubs and MDT meetings for case study discussion) would assist members to achieve these requirements. All professions undergo a process of evolution and future medical practice is likely to incorporate a range of forms of practice. The challenge is for regulatory and professional bodies to acknowledge, support and respond to the dynamic nature of these forms. It is proposed that a comprehensive survey at a national level be conducted to ascertain members' views on these issues.

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Dr Dilip Dhupelia,
President AMA Queensland
and
Jane Schmitt,
CEO AMA Queensland

2019 Queensland Budget Submission

Ahead of the 2019 State Budget, we presented our pre-budget submission to the Queensland Health Minister Steven Miles, with seven recommendations.

1. **Helping GPs Become Real Time Ready**: With the introduction of real time prescription monitoring (RTPM) in Queensland imminent, we have asked the Queensland Government to provide funding to educate GPs on the new system and help their practices to meet IT requirements where necessary.
2. **Wellbeing at Work resilience program**: We are seeking funding to continue delivering this program to all interns and to extend it to the PGY 2-5 years. The program aims to help junior doctors cope with the pressures, conditions and demands of their jobs.
3. **Mandate water fluoridation:** AMA Queensland is urging the State Government to mandate fluoride in all Council water supplies across Queensland.
4. **Add Spinal Muscular Atrophy to newborn heel test:** AMA Queensland calls for a trial to add childhood motor neurone disorder, Spinal Muscular Atrophy (SMA), to the newborn heel prick test, following the lead of New South Wales and the Australian Capital Territory.
5. **Establish an Office of Sustainable Healthcare** to reduce costs to Queensland Health in energy use and climate change emission.
6. **Public Health Awareness Campaign on Obesity:** AMA Queensland calls on the Government for assistance in funding and developing a collaborative, innovative public education campaign to battle obesity, curb chronic disease rates and promote healthy lifestyles.
7. **Encourage local council to invest in public health infrastructure**, such as building extra bikeways, public exercise equipment and better-lit walking paths to promote healthier lifestyles across Queensland communities.

Our Budget submission, which draws on the collective experience of our members at the coalface of delivering health services in Queensland, acknowledges the important contribution of State Government, local councils, community organisations and the general public to improving the health of Queenslanders.

We look forward to working with the Queensland Government on the initiatives herein.

Mandatory reporting update

On 26 February, the Queensland Parliament passed the Mandatory Reporting Laws as part of the *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018* without amendment.

The decision flies in the face of AMA's strong advocacy on the issue. AMA has gone to great lengths – appearing at consultations, writing submissions, talking to governments – over many years to highlight how this policy works, and why it needs to change.

We have fought hard to make it easier and more acceptable for health professionals to seek treatment and get help for their own health condition.

Latest advocacy

In February, AMA Federal and AMA Queensland advocated for the Queensland Parliament to adopt the 'WA-lite' model as we know it works well to protect patients and save doctors. It relies on health practitioners' ethical and professional obligations to report a practitioner-patient who may put public safety at risk. There is no evidence to suggest diminished patient safety in WA.

This advocacy included meetings with the Health Minister and Minister Ambulance Services, Steven Miles; a meeting with Shadow Health Minister and Minister for Ambulance Services, and Minister for Women, Ros

Continued Page 11

NEW
MEDICAL CENTRE OPENING SOON

292

ANZAC AVENUE
KIPPA-RING QLD

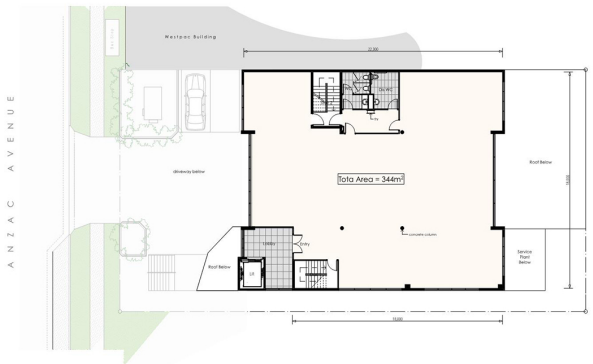
DON'T MISS THIS FANTASTIC LEASING OPPORTUNITY!

292 Anzac Ave is a stand-alone private medical centre due to open in mid 2019.

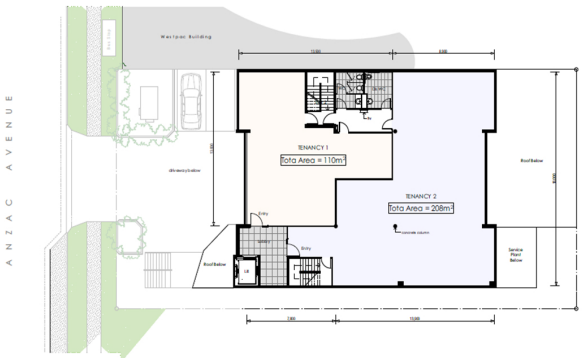
The centre is primely located, provides excellent exposure with onsite signage and street frontage on to busy Anzac Avenue, plus has great accessiblity and onsite parking.

With Level 1 already secured by I-Med Radiology Network, the centre offers an unbeatable opportunity for either one or two medical businesses to lease Level 2 and establish themselves in this growing area.

OPTION 1
Total Area: 344m2



OPTION 2
Area 1: 110m2 | Area 2: 208m2



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Bates; media interviews and a joint letter to all MPs seeking bi-partisan support for the Bill to be passed with the amendment.

Next steps
We will not give up. AMA Queensland will continue to advocate for changes to mandatory reporting laws in Queensland, particularly in the lead-up to the State election next year.

Aged care, Palliative care and Voluntary Assisted Dying

The Queensland Parliament is holding an inquiry into aged care, end-of-life, palliative care and voluntary assisted dying, with a report due by November 2019. An issues paper has been released.

AMA Queensland has been invited to prepare a submission to the inquiry and, after seeking views of members last year, AMA Queensland Council has sought advice from the Ethics and Medico-legal committee on to how to proceed, particularly as Euthanasia and Voluntary Assisted Dying becomes legal in Victoria on 1 July 2019, with other states commencing similar enquiries.

At the February meeting of the Ethics and Medico-Legal committee, members discussed whether we should adopt the AMA position statement on Euthanasia and Physician Assisted Dying.

We will engage with as many members as we can to ensure the submission to the inquiry captures and respects the consensus view of as many members as possible. You can provide your feedback to policy@amaq.com.au.

AMA Queensland is also collaborating with Palliative Care Queensland to develop a public health approach to palliative care.

2019 AMA Queensland elections

Nominations will open on 25 March at 5pm for the positions of President, Vice President, Chair and Council positions.

More information about the new positions and requirements for being a councillor will be provided via email and on the AMA Queensland website once nominations open.

The election results will be announced at our AGM on 17 May 2019.

If you have any issues you feel need AMA Queensland's attention, please send us your thoughts directly via membership@amaq.com.au.

Dr Dilip Dhupelia, President AMA Queensland **Jane Schmitt**, CEO AMA Queensland

Interesting Tidbits NATTY MOMENTS:

Brain Teasers

1. Johnny's mother had three children. The first child was named April. The second child was named May. What was the third child's name?

2. A clerk at a butcher shop stands five feet ten inches tall and wears size 13 sneakers. What does he weigh?

3. Before Mt. Everest was discovered, what was the highest mountain in the world?

4. How much dirt is there in a hole that measures two feet by three feet by four feet?

5. What word in the English language is always spelled incorrectly?

6. Billie was born on December 28th, yet her birthday always falls in the summer. How is this possible?

7. In British Columbia you cannot take a picture of a man with a wooden leg. Why not?

8. If you were running a race and you passed the person in 2nd place, what place would you be in now?

9. Which is correct to say, "The yolk of the egg is white" or "The yolk of the egg are white?"

10. A farmer has five haystacks in one field and four haystacks in another. How many haystacks would he have if he combined them all in one field?

Answers

1. Johnny.
2. Meat.
3. Mt. Everest. It just wasn't discovered yet.
4. There is no dirt in a hole.
5. Incorrectly (except when it is spelled incorrecktly).
6. Billie lives in the southern hemisphere.
7. You can't take a picture with a wooden leg. You need a camera (or iPad or cell phone) to take a picture.
8. You would be in 2nd place. You passed the person in second place, not first.
9. Neither. Egg yolks are yellow.
10. One. If he combines all his haystacks, they all become one big stack.

Submission for the Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying by Dr Peter Stephenson. Submissions closed on the 15th April 2019

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7/3/2019

Committee Secretary
HCDSDFVPC
PARLIAMENT HOUSE QLD 4000.

Dear Sir/Madam,

It is with great optimism that I am writing to you today as a Family GP in the hope that we will get a Dying with Dignity legislation through the Queensland Parliament. I was at the Forum in the parliament on this subject on the 25th July 2018 and was sorry NOT to see more MP's there.

With my 42 yrs of family GP, I have seen people suffer unnecessarily from terminal diseases where the symptoms of dying cannot be controlled adequately by current management techniques.

If only we had medications to control pain absolutely without side effects. A Holy Grail.

Narcotics relieve pain, but have constipation as a major side-effect, as well as narcosis, a feeling of being doped up or zombified and unable to enjoy life while waiting for the inevitable relief by actually dying.

Nausea can be controlled somewhat by today's therapies, but the best treatment (ondansetron) is not on the PBS as it is quite expensive at $10.00 per tablet.

There are conditions that just cannot be controlled like intestinal obstruction where the patient vomits their faeces. One patient I recall had a fungating tumour of her face and one could see into the back of her throat and the odour from it when the dressing was changed flooded the whole ward.

I have just had a male patient aged 60yrs old who requested to die at home last September. He was riddled with prostate cancer after 15yrs of being in and out of hospital, the last few times having to have blood transfusions every two weeks. He was having great difficulty getting out of bed to go the toilet from the pain and weakness. He was worried that if he fell over, his wife would not be able to pick him up and the ambulance would take him to hospital to die.

I therefore agreed to provide him terminal sedation under the care of his wife and Karuna Home Hospice Care, an excellent service that I support financially. It took him almost exactly seven (7) days to die from dehydration. I repeat: it took him almost exactly seven (7) days to die from dehydration. The Karuna Nurse said that this length of time was not unusual. Not surprisingly, his wife has been traumatised by this and needs counselling, probably for the rest of her life, even though she did her amazingly best for her dear husband.

I could easily go on with more examples but I will not.

Therefore we need to have the means to euthanase people who have terminal illnesses at their request when their lives are just a living hell.

Best Regards

Dr Peter Stephenson M.B.B.S.(Lon.) L.R.C.P.(Lon), M.R.C.S. (Eng)
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AMA

PATIENTS WITH CHRONIC WOUNDS NEED BETTER SUPPORT

The AMA today called for better Medicare support for the hundreds of thousands of Australians suffering from hard-to-heal wounds, and for the GPs and health teams treating them.

The AMA has made its initial submission to the Medicare Benefits Schedule (MBS) Review Wound Management Working Group, which is reviewing MBS items around wound care.

The AMA has recommended Medicare subsidies be provided for the cost of providing bandages and dressings to patients when they visit their GP.

AMA President, Dr Tony Bartone, said it is estimated that more than 400,000 Australians are suffering from a chronic wound, including venous leg and diabetic foot ulcers, which can take months or even years to resolve.

"This can involve multiple visits to GPs and practices to have dressings changed, and to discuss nutrition, exercise, and other ways the patient can look after their wound themselves to help the healing process between appointments," Dr Bartone said.

"Many of these patients are older Australians. Many are on limited or reduced incomes, due to their stage of life or their reduced capacity to work due to their condition.

"Wherever possible, their GP will bulk bill patients for their care. But GPs and practices are increasingly unable to absorb the cost of providing the bandages and dressings that their patients need each visit – which can cost between $4 and $50 per patient.

"Under Medicare restrictions, GPs cannot bulk bill a patient for a consultation and charge the patient just the cost of the bandage.

"This means that they have to decide between bulk billing the patient and absorbing the cost of the bandage themselves, or charging the patient for both the consultation and the dressing.

"General practices, after years of frozen and inadequate rebates for the cost of care, are just not in a position to subsidise this cost.

"In many cases, patients buy their bandages or dressings at market rates from a pharmacy, just so the GP treating the wound can bulk bill them for the consultation without falling foul of legislative restrictions.

"Chronic wounds are debilitating for patients, causing a myriad of complications including constant pain, social isolation, and depression or anxiety, and the cost of bandages and dressings is prohibitive for many people.

"As such, there is an imperative for the Government to support best practice care."

The AMA has suggested two possible solutions:

- Provide general practices with a stock of Government-funded dressings; or
- Develop a wound consumables schedule that GPs could bill against to cover the costs of dressings and bandages provided to patients.

MEDIA RELEASE

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PATIENTS WITH CHRONIC WOUNDS NEED BETTER SUPPORT

Initially, these solutions should be targeted at patients with diabetes with foot or leg ulcers, patients with venous or arterial leg ulcers, and patients 65 years or older.

"This would provide patients with access to appropriate dressings and improve the overall quality of care for patients," Dr Bartone said.

"The AMA urges the Working Group to consider these solutions.

"The AMA supports a GP-led, team-based approach to care, utilising the skills and knowledge of other health professionals including nurses, pharmacists, allied health professionals, and other specialists.

"We would encourage the Working Group to ensure that any recommendations they make support GP stewardship, and do not undermine the collaborative care arrangements already in existence between these teams."

The AMA will make a further submission when it has completed reviewing the draft recommendations made by other MBS Review groups around acute wound items.

The AMA submission is at https://ama.com.au/submission/initial-ama-submission-wound-management-working-group

Background

- In 2014, researchers from the Queensland University of Technology estimated the direct health care costs of chronic wounds at about $3 billion a year.
- About 48,000 Australians, mostly older people, are estimated to suffer from venous leg ulcers every year.
- Venous leg ulcers take a minimum of 12 weeks to heal.
- In 2003, KPMG estimated that the use of compression bandages for patients with venous leg ulcers could save $166 million a year.
- Four-layer compression bandages cost about $50.
- The Medicare rebate for a Level B consultation is $37.60.
- In April 2017, the AMA wrote to Health Minister Greg Hunt, calling for a review of the prohibition on GPs charging for consumables, such as wound dressings, when they bulk bill a wound management service.

---

14 March 2019

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Magnificent Abu Dhabi by Cheryl Ryan

Abu Dhabi, the contemporary capital city of United Arab Emirates, is an epitome of change in the modern era from a fishing village to World business Capital.

The city is associated with many feats and world records such as fastest roller coaster, largest hand loomed carpet, and the tower with greatest lean. The city offers a unique experience of an ultra-modern city, engaging visitors with its enticing Gulf culture and Islamic religion.

Cuisines

Abu Dhabi is one of the world's ultra-modern villages, where you can find cuisines from all over the world. If you are a true foodie, then you don't want to miss an opportunity to taste authentic Gulf cuisines, prepared with native ingredients and spices from Asia and Middle East, reflecting the cultural trading history of United Arab Emirates. The famous dishes are Al Harees, Al Majboos which are made from fresh meat, blended with spices and herbs. Fish is one of the major components of Food in the country with the known dishes being Al Madrooba, a mix of salted fish along with spices and sauce.

Some of the famous restaurants serving authentic gulf cuisines can be found in Al Dhafra Tourist Village and Arabian Nights Village.

Arabian Nights Village

Located amidst the valley of Sand dunes, Arabian Nights Village perfectly captures the essence of old Arabian cultures, giving visitors an experience of beautiful desert life. The village offers different accommodation types, suiting different requirements and lifestyles of the region. There are various recreational activities available such as camel rides, quad bikes, morning desert safari and Dune bashing.
For Adventure Seekers

Abu Dhabi is renowned all over the world for its Desert Safaris which is a whole different experience in itself. Taking a 4x4 tour in sands on hot afternoon, accompanied with camel riders, enjoying the spectacular desert sunset while savoring barbeque delicacies, in midst of belly dancing performance definitely makes up unforgettable memories of lifetime. Abu Dhabi also offers some automobile adventures such as BloKarting, Gokarting, Dirt biking, Dune Buggying, sandboarding and sky diving.
The best adventure to fuel your adrenaline is Ferrari World's Formula Rossa, which is world's fastest roller coaster boasting speed of 240 kmph and lets you experience G-Force of 4.8.

What we have planned for you?

A detailed itinerary has been put together so that you don't forget to look beyond the Desert in Abu Dhabi and miss exciting activities
• A 4x4 Desert Safari, a camel ride, Dune Buggying in the day and dinner alongside campfire with belly dancing performance
• Visit to Arabian Nights Village, experiencing the unique cultures and traditions of the region
• A visit to Sheikh Zayed Grand Mosque Center, which is a must-see site in Abu Dhabi
• Visit to Al Arish, an authentic Gulf food serving restaurant in the Al Dhafra Tourist Village, savoring the native cuisines

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BUYING OR GIFTING SHARES TO A MINOR

We are seeing an increase in parents and grandparents wanting to buy/gift shares for their minor grandchildren. From this we are commonly asked about the process and ramifications of buying shares for, or gifting shares to, a minor. Below are some scenarios and commonly asked questions to help with your decision. (*G. = the person gifting the shares.)*

Scenarios:

Gifted Shares, Minor Receives Income:

- G. buys shares on behalf of minor;
- Any dividends received go into minor's bank account;
- Minor declares the dividends on tax return;
- When the shares are sold, any capital gain or loss will belong to the minor.

Gifted Shares, G. Puts Shares in Minors Name but G. wants the Income:

- G. buys shares in minor's name;
- G. receives dividends and uses for personal expenses;
- G. declares dividends on tax return;
- When the shares are sold, any capital gain or loss will belong to G.

Gifted Shares, G. Puts Shares in Their Name but Will Give to Minor Later:

- G. buys shares in their name;
- Dividends are declared by G.;
- When minor turns 18, ownership of shares is transferred to minor;
- Shares are treated as if they were disposed at their market value, which may incur capital gain or loss for G.;
- Minor is now in full control of shares, any capital gain or loss from selling shares will now belong to minor.

Commonly Asked Questions:

What if the minor doesn't have a TFN?

Unless working, the majority of minors will not have a tax file number (TFN). When you buy shares you are asked to provide a TFN and if not provided then Pay as You Go (PAYG) tax will be withheld at 47% from any unfranked (untaxed) dividend income received.
If you do provide a TFN when buying shares, you pay taxes on the dividends when the tax return is lodged. If the shareholder is a minor with a TFN, you should provide the minor's TFN at the time of purchase. In the instance a parent or grandparent is the trustee for the minor, provide the parent or grandparents TFN.

Who declares the dividends?

Whoever rightfully owns the shares (whoever's name they are in) needs to declare the dividends, along with any net capital loss or gain from the sale of shares.

When should a minor with shares lodge a Tax Return?

If a minor owns shares and earns more than $416, a tax return is required to be lodged. If less than $416 a tax may still be required to recover franking credits. If in doubt check with your accountant.

Do all trading sites allow trading on behalf of minors?

No. Not all sites are able to trade on behalf of minors, such as Commsec. What you can do is open an account in the name of an adult who will act as trustee until the minor turns 18. The shares can then be transferred into an account in their name. Beware of the capital gains tax that may apply through doing this.

If you would like to discuss this matter please feel free to call us on 07 54379900.

Article written by Madison Kapper. References used ATO and Commonwealth Securities Limited.

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NEW NATIONAL MEDICAL WORKFORCE STRATEGY WELCOME, BUT LONG OVERDUE

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA congratulates COAG Health Ministers who today agreed to work collaboratively to fund, develop, and implement a new strategy for a national medical workforce to meet Australia's future healthcare needs.

AMA President, Dr Tony Bartone, said today that the new strategy – the first since the National Health Workforce Strategic Framework 14 years ago – will allow the Commonwealth and the States and Territories to cooperate more closely in planning and coordinating our future medical workforce.

"It is vital that this strategy addresses and overcomes the many workforce challenges facing Australia's medical professionals," Dr Bartone said.

"These include the maldistribution of the medical workforce, workforce shortages in some specialty areas, and the lack of prevocational and specialist training places for medical graduates once they have left medical school.

"The Commonwealth is responsible for funding medical schools and general practice training, and has programs to support medical training in community and private settings, but most medical training still takes place in State and Territory public hospitals.

"We need a seamless process and we need an end to the blame game over funding."

Dr Bartone said the AMA has been calling for the new strategy for many years, and it was a key recommendation from the 2018 AMA Medical Workforce and Training Summit.

The AMA Summit also called for:
• better support for generalism;
• a focus on matching training with community need;
• more opportunities for specialist training in rural areas;
• the development of a strong rural training pathway; and
• supporting careers in undersupplied specialties.

"A national medical workforce strategy, developed with strong input from the profession, is critical to getting all stakeholders on the same page to achieve policies that will deliver the future medical workforce that the community needs," Dr Bartone said.

"The new strategy is welcome news for our patients, our local communities, and our specialists-in-training."

The Report from the 2018 AMA Medical Workforce and Training Summit is at https://ama.com.au/medical-workforce-training-summit

8 March 2019

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2) Or Emailing to GJS2@internode.on.net

"Bravery Under Fire: Sister Claire Trestrail"

Audacity: Stories of heroic Australians in wartime. Website: www.dva.gov.au

Bravery under fire: Sister Claire Trestrail

The streets of Antwerp were ablaze, and enemy shells exploded on the roof of the hospital. Sister Trestrail struggled under the weight of a patient she had on her shoulders as she tried desperately to get down the stairs to the cellars. With more than 100 patients and very little time, Claire and her fellow nurses knew that somehow they had to get them to safety.

Born in Clare, South Australia on 10 December 1887, Evelyn Claire Trestrail, or Claire as she was known, was the oldest of Henry and Constancy's five children. Having always respected her mother's commitment to nursing, she decided at the age of 18 to become a nurse herself.

In late 1913, Claire set sail for England with nursing friends Catherine Tully and Myrtle Wilson. Claire joined the Scottish Women's Hospital and all three women were still in England in 1914 when war broke out. Nurses were needed immediately, and Claire and her friends joined the privately funded Auxiliary Hospital Unit. Its organiser, Mrs St Clair Stobart, was experienced in military medicine, having established a military field hospital during an earlier conflict.

Within a month, Claire and 11 other nurses set off on a stomach-churning sea journey towards the front line in Belgium.

The group took over a concert hall in the city of Antwerp, which they quickly transformed into a 120-bed hospital. The building was soon overflowing with more than 170 badly wounded French and Belgian soldiers. Claire remembered that "some of the men had been lying for hours in the dirt and cold until the blood was dry on them, and they were hungry and exhausted".

The Germans were advancing from the south,

Claire wearing a Queen Alexandra's Imperial Military Nursing Service Reserve (QAIMNSR), Uniform, 1916. AWM P08673.003

and the hospital came into the direct line of fire. One October night Claire and her friends were roused from their sleep as shells flew over the building. The city was under attack. The nurses rushed to the hall and, using all their strength, they carried their patients, one by one, to the cellars below. Mrs Stobart reported:

Slight, frail nurses carried heavy men on their shoulders … Shells were bursting all round, but never once did I see anyone taking the slightest notice of them. The nurses' coolness was marvellous.

The End.