REDCLIFFE & DISTRICT and BRISBANE LOCAL MEDICAL ASSOCIATION

RDMA & BLMA's Joint Newsletter

Newsletter
MAY 2019

MBAQ Can Help "Though I cannot express my gratitude to the team at MBAQ and its donors in words, it is my endeavour to spread the message that MBAQ has made a huge difference in our lives. The assistance was very generous and also timely. I am not a Christian, but I quote The Bible here -"Ask and it is given"...best exemplified by MBAQ."

See Where We Work & Live P20. MBAQ Can Help

RDMA President's Report Dr Kimberley Bondeson

Presidents Report – May 2019

We are now having beautiful cool mornings, around 12 degrees, which is cool for this time of year. It makes me think we are in for a particularly cool winter, which will be very welcome after the extremely hot summer we have just had.

By the time this article is published, we will have had our Federal Election, and will know which party or parties hold the balance of power in the political arena of Canberra.

The election campaign has been an interesting one, which each party seeming to match the others promises, one type of campaign which I have not seen before.

What difference this will make to the medical profession and health for the population will need to be seen.

I have always been curious as to how each political party is able to make promises, and then when they get into power, often retract or change what they have promised.

Then I read an article that stated that political parties can't be sued for false advertising or promises. There are several articles on this topic, from around the world.

"The subject matter, nature and context of a promise of this kind place it in the realm of politics, not of the courts" and the question whether the government should be held to such a promise is a political rather than a legal matter".

So, there is one explanation: political promises of the kind each party makes in its manifesto are not legally enforceable. If you want to enforce them, you'll have to use the ballot box – or run for parliament yourself. – taken from the Telegraph r(Wheeler) v Office of the Prime Minister and Secretary of State for Foreign and Commonwealth Affairs, by Lawrence Dodds, BST 18th April 2015.

So, is this happening in Australia?

Very likely.

And the promises made by each party and their leaders and candidates?

Well, it is to be seen if they are followed through, and what, if any, are benefits to the medical profession and our patients.

Dr Kimberley Bondeson

RDMA & BLMA's Joint Newsletter

Welcome from

Dr Robert (Bob) Brown

President Brisbane Local Medical Association

Note: Doctors in Training
RDMA Membership is Free
RDMA & BLMA Meeting Dates Page 2.

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

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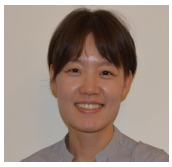

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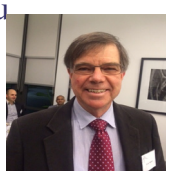

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UPDATED

RDMA 2019 MEETING DATES:

For all queries contact Anna Wozniak or Amelia 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	23rd
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 June 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 23rd April 2019

RDMA February Meeting for 23.04.2019

Dr Kimberley Bondeson RDMA President Introduced Sponsor Representative: Drake who then introduced the Speakers for the night:

Speaker
Dr John Teh, Cannabinoid Clinician and Clinical Educator
Topic 1: "Introduction to Medicinal Cannabis"
Sponsor: Tiray
Photos (Down Left to Right & Down):
Speaker Dr John Teh with Drake Shikhule

New Members:
Julie O'Connor & Leslie Williams
Darius Khasembashi & David Dowden
Geoff Hawson, New Member Mitsi Blazos, New Member Lauren Anders and Chris McLaren
Nardia Fladen and Neal Nguyen

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 29th of May 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	Sponsor: Eli Lilly
7:40pm	Speaker: Dr Rakesh Malhotra, Endocrinologist Topic: "Rethinking the First Injectable: a case-based approach to incorporating Trulicity into your practice."
8:00pm	Main Meal served
8:20pm	Question Time
8:30pm	Dessert, Tea & Coffee served
8.40pm	General Business

RSVP: By Friday 24th of May 2019
(e) RDMA@qml.com.au or 0466 480 315

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

Incentives for Vaccinations and My Latest Conference Experience (continued page 6)

In the past few months, there have been two reports of unvaccinated children travelling into Australia on long international flights with active measles. Australia has reported an unusual increase in the (reported) cases of measles unrelated to those incidents. The United States is reporting the largest outbreak of measles in 30 years.

The annual Australian government-subsidised influenza vaccine has been released a month earlier than usual, with the Queensland Chief Medical Officer suggesting that mid-April is the optimum timing for influenza vaccination (most vaccines have been given in May in previous years). The demographic of potential candidates for government-subsidized influenza vaccines has been expanded and there are now three different vaccines targeted for different age groups. This is on the background of an unexpected epidemic of influenza A, with more cases being reported so far this year than were reported last year, and a substantial number of deaths, especially among the elderly – and we are nowhere near the expected flu season of August-September.

There appears anecdotally to have been an upsurge in the number of cases of shingles, herpes zoster, and an unexpected number of cases of chicken pox, presumably mostly in unvaccinated children.

Vaccination rates in Australia are relatively good, but there are notable exceptions. The are pockets of anti-vaxxers especially in communities noted for their alternate lifestyles (including a cluster on the Sunshine Coast where I work). The first general principle is that citizens of a free society should be free to make their own decisions about their own health and the health of those for whom they are responsible. That principle holds true even when those decisions are based on falsely held beliefs – as long as the decision-makers have been given reliable factual information. The second general principle is that citizens are, subject to provisos, at liberty to place themselves and their dependants at risk, provided that they do not create an undue risk to others around them. This is where the debate about antivaxxers is concentrated – (a) if their children acquire vaccine-preventable illnesses, the cost of immediate and long-term care will fall on the taxpayer, and (b) if unvaccinated children acquire an illness and then expose unknowing members of the public (such as co-travellers on long-haul aeroplane flights and the masses of people passing through airports, or just the other children in their schools and playgroups), they are risking the wellbeing of others who have no knowledge of the hazard to which they are being exposed.

The “no-jab no-pay” policy provides a negative incentive for parents who neglect to or refuse to have their children vaccinated. [It is debateable whether is a positive or negative incentive to withhold a government benefit that would otherwise be available but is now contingent upon performance of a particular qualifying activity.] Can this be extended? Some local governments in the USA have banned unvaccinated children from public places (but how can this be enforced or even identified?) Is it ethical in Australia to publish lists of unvaccinated children, either generally or even specifically to interested parties such as schools? We cannot leave our dogs at boarding kennels without a current vaccination certificate. Can we ban children from public schools, or other group activities such as sporting clubs, if they have incomplete or absent vaccination records? Can transport carriers be required to sight a current vaccination certificate before issuing an international ticket for a child under school age?

Your correspondent has tabled a discussion paper with the Ethics and Medico-Legal Committee of AMAQ to ask the Council to consider whether the time is right to canvas extensions to the incentives to improve our vaccination rates above the current imperfect level of achievement.

MY LATEST CONFERENCE EXPERIENCE.
I recently attended a conference on Emergency Medicine, although it was geared towards primary care level rather than DEM level. Although an American conference, I was bemused that nearly half of the participants were from Australia.

It was interesting to remark on some of the differences between North America and Australia in medical practice and outcomes.

Most Americans do not have health insurance. All Australians have basic health insurance, i.e. Medicare. The cost of full private cover in Australia (say $4K per family) was dismissed by the Americans as a trivial cost. Whether you like Medicare or not, the outcome is that Australia has nearly the highest life expectancy in the world, while the USA position is somewhere in the 30’s. Wealthy Americans get expensive high-tech medicine; nearly half of Americans struggle to achieve even basic care. Most Americans get basic medical care and do not have affordable access to care that

CONTINUED FROM PAGE 5

we regard as being fairly standard such as interventional radiology.

American doctors largely do not practice preventive medicine. Australian GP's spend most of their time practising preventive medicine.

The biggest contrast in our discussions was in vaccination rates. Australia performs very well on the international scene, despite the anti-vaxxers. We have essentially free universal childhood vaccination and fairly generous adult vaccination. We have the no-jab no-pay policy to encourage the parents who are just too busy to attend, but that seems to have little effect on the anti-vaxxers.

Schedule 8 doctor-shopping is rampant, but they have reduced the incidence by legislation requiring prescriber to check online live prescription records. Victoria already has this legislation; Queensland will enact similar legislation soon. As in Oz, they have problems with rogue prescribers, "pill factories", who prescribe controlled substances beyond the guidelines and regulations. Unlike Oz, their regulatory bodies possess and use punitive powers which go as far as jail sentences for improper prescribing. In my practice, where I struggle against prescribers who exercise autonomy over discretion, I would be happy to see our regulatory bodies given more appropriate powers and resources to enforce the legislation.

I discussed the current Australian ice epidemic. American GP's found this a mystery. Is that because they don't have as much of an ice problem? Or is it because their GP's don't see uninsured patients, which includes most amphetamine addicts?

Medication costs are sometimes more of a barrier to medical care in USA than the costs of seeing a doctor. I was surprised to learn that patients can get free inexpensive antibiotics from Costco (or their generic of Costco). States which have legalized marijuana have recorded a syndrome of cyclical vomiting caused by THCA, and a propensity to have prolonged hot showers to the point of developing AKI. This one was new to me.

The average American doctor is sued once every 5 years, and they expect to spend up to 10% of their time involved in a legal process. Neurosurgeons expect to be sued once every 2 years, and to be involve in a legal process more or less all the time. Most are settled out of Court, more for reasons of economic expedience than on the merits of the case.

AMAQ BRANCH COUNCILLOR REPORT

Dr Kimberley Bondeson, Greater Brisbane Area

AMAQ Elections and Voluntary Assisted Dying (VAD)

AMAQ has just had its elections for its office bearers, and I would like to congratulate Dr Dilip Dhupelia who has again been elected as President for a second term. This will allow Dr Dhupelia to continue with some of the projects he is passionate about. I would also like to welcome Dr Chris Parry, who is our new AMAQ Vice-President. Dr Parry, an ENT Surgeon in public and private practice in Brisbane, is a welcome addition to the team. He brings vast experience, and in the past been involved in AMAQ Council.

One of the important topics that was discussed at the recent AMAQ Council Meeting was an update on Voluntary Assisted Dying (VAD). There is new legislation being introduced in Victoria, which is effective from the 17th June, 2019, which makes this legal. In a nutshell, the patient must be a competent, consenting adult, with a disease, illness or medical condition that is: Incurable; and advanced, progressive and will cause death; and expected to cause death within weeks or months, not exceeding 6 months (12 months for neurodegenerative); and causing suffering to the person that cannot be relieved in a manner that the person considers tolerable. They are not eligible if the disease is only mental illness or disability. They must be assessed by 2 independent doctors. The patient must make the request for VAD on 3 separate occasions, 2 weeks apart. The doctor must then apply for pre-authorisation (for issue of a permit, for VAD, which will take 3 working days to process).

The Victorian Legislation has written in that there is Prohibition on raising the topic of VAD. Health Practitioners are prohibited from initiating end of life discussions with patients. The Victorian law around this topic is very complex and complicated. How this pans out, and the consequences, intended and unintended of this law in Victoria will be monitored.

Queensland, on the other hand, is progressing on this topic in the following manner. There Is a Voluntary Assisted Dying Bill draft which has been proposed by Professor Lindy Willmott and Professor Ben White, academics and lawyers, from the Queensland University of Technology, The Australian Centre for Health Law Research. They specialise in this topic, and have been researching it for many years. They have put together a proposal for the Queensland Government to consider. It is a much shorter document (25 pages, as opposed to the Victorian Legislation which is 128 pages), with the major differences as follows:

It allows open discussion between Health Practitioners and patients on VAD, and it avoids the need for an application for a permit, once the patient has been assessed. This is to avoid complicated and lengthy bureaucratic paperwork. Again, this is only in its draft form, and these Professors were not approached by any group, or government body, to put their submission together. They are also carefully watching the Victorian legislation, and how VAD will work, in particular looking for any unexpected consequences of the legislation. How Queensland will progress on this topic is ongoing. Kimberley Bondeson

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 25th of June 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	Sponsor: Bristol Myers Squibb
7:40pm	Speaker: Dr Alaa Alghamry, General Medicine/Stroke Physician Topic: "It's all about safety: Practical tips to improve anticoagulation management in Atrial Fibrillation"
8:00pm	Main Meal served
8:20pm	Question Time
8:30pm	Dessert, Tea & Coffee served
8.40pm	General Business

RSVP: By Friday 21st of June 2019
(e) RDMA@qml.com.au or 0466 480 315

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

Patients will be the losers in new pharmacy trial

In April, Health Minister Steven Miles handed down his response to the Queensland Parliament Committee's 11 recommendations regarding the establishment of a pharmacy council and expanded scope of practice for pharmacists. The Minister announced that Queensland Health would launch a state-wide trial allowing pharmacists to provide the pill and antibiotics on a one-off basis without a prescription.

This decision flew in the face of AMA Queensland's strong advocacy on the issue. Over the past months, we went to great lengths – appearing at consultations, writing submissions, talking to Government and Members of Parliament, launching a strong media campaign – to push back against the committee report's recommendations and highlight the dangers of the proposal.

It is simply irresponsible and reckless to allow medications to be provided without doctors' advice.
We will not give up.

We will call on the Queensland Government to reconsider its decision and we will continue to fight with the ultimate aim of ensuring patient safety is protected.

Urgent issues confronting ED Physicians

In response to members' concerns about significant problems confronting staff in emergency departments across the state, AMA Queensland and the Australasian College for Emergency Medicine (ACEM) met with the Health Minister, the Director-General and their team to discuss the issues and to broker solutions.

In particular, in conjunction with ACEM, we recommended that Queensland Health adopt five solutions to help improve patient access and help manage doctors' workloads.

As a result of this consolidated team effort, we received confirmation from members at Logan Hospital that Queensland Health and Metro South Health had acted upon our recommendations and had implemented a number of short term solutions. Queensland Health also advised us that the Redland Hospital emergency department had allocated a priority vehicle for transferring patients out of the hospital and that this had been immediately actioned.

While we are pleased with this outcome, we consider this to be a start to ongoing improvements for emergency department staff and patients across the state.

We are also meeting with emergency department staff from other hospitals in Queensland and we will continue to work with Queensland Health to ensure a state-wide, systemic response is implemented and emergency departments are appropriately resourced and supported to respond properly to community health needs.

Aged Care and Palliative Care in Queensland - What's needed?

In April, AMA Queensland provided two submissions to the inquiry into aged care, end-of-life and palliative care and voluntary assisted dying being held by the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's (HCDSDFVPC).

We will provide our submission into voluntary assisted dying after the next Council Meeting to ensure our response to the inquiry captures the consensus view of members as best as we can.

Aged Care

AMA Queensland is seeking urgent action by the Commonwealth Government in the following areas to ensure a high standard of comprehensive care in Residential Aged Care Facilities (RACF).

1. Introduce **minimal acceptable staff ratios** in line with the care needs of residents including registered nurses, allied health, psychologists and personal care staff including coordinated access to multi-disciplinary teams.

Continued Page 10

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Continued from Page 8

2. Review item numbers under the MBS to **support increased use of telehealth**.
3. Work with RACF to **develop a streamlined electronic documentation system** which enables service providers (including General Practitioners) to access patients' records.
4. Ensure the **remuneration for General Practitioner** under the Medical Benefits Scheme (MBS) matches the cost of providing the care, by supporting an increase in the remuneration for episodes of care in RACF by General Practitioners.

Palliative Care

AMA Queensland recommended the following actions to address the gaps in palliative care in Queensland.

1. **Assess the unmet need** for Palliative Care
2. For the **Queensland/Federal Governments to jointly fund** comprehensive palliative care services for all Queenslanders supported by a coordinated strategic framework
3. Establish **designated multi-disciplinary palliative care service units** within each region of Queensland
4. Support **specialised palliative care training and education** for all providers of palliative care within the medical, nursing and allied health professions, as well as within the community generally
5. Queensland Health and the Queensland Clinical Senate should **develop a comprehensive set of guidelines** as to when clinicians should discuss advance care planning with their patients
6. Aim for 50 at 50 – aim for 50 per cent of Queenslanders aged 50 or over to have an advance care plan.

You can read the full submissions into Aged Care and Palliative Care at www.amaq.com.au.

Dr Dilip Dhupelia, President AMA Queensland

DR SHARON HENG

Medical Oncologist and Palliative Care Physician
MD, FRACP (Med Onc), FAChPM
Moreton Bay Cancer Care

NORTH LAKES
HAEMATOLOGY & ONCOLOGY CLINIC
- Montserrat Cancer Care -

North Lakes Haematology and Oncology Clinic welcomes Dr Sharon Heng

Complimenting existing oncology services, Dr Heng joins North Lakes Haematology and Oncology Clinic specialising in:

- Breast cancer
- Gastrointestinal cancer
- Gynaecological cancer

Dr Heng is a dual-trained Medical Oncologist and Palliative Care Physician. With a focus on the most up-to-date treatment, she aims to provide compassionate patient-centred cancer care services to the growing Moreton Bay region.

Dr Heng takes the time to understand her patients' needs, supporting and guiding them throughout their care. She integrates patients' general wellbeing into all aspects of their treatment by focusing on their emotional and mental wellbeing, fitness and nutrition.

Striving to achieve the best possible outcome for each patient, Dr Heng works closely with other members of the medical community, ensuring her patients receive comprehensive care and treatment through all stages of their cancer journey.

Qualifications

Fellow of the Royal Australasian College of Physicians (FRACP) in Medical Oncology, 2017
Fellow of the Australasian Chapter of Palliative Medicine (FAChPM), 2018
Doctor of Medicine (MD), Universiti Putra Malaysia, 2007

Clinical Trials and Research

Dr Heng actively participates in clinical trials, has presented research at both national and international conferences and has had research published in internationally recognised medical journals.

Clinical Experience

Dr Heng undertook physician and advanced training in medical oncology and palliative care in major hospitals throughout South East Queensland including the Royal Brisbane and Women's Hospital, Princess Alexandra Hospital, Gold Coast University Hospital and Mater Hospital Brisbane. Upon completion of her advanced training, she consulted in Gold Coast University Hospital before founding Moreton Bay Cancer Care.

Professional Memberships

Medical Oncology Group of Australia (MOGA)
European Society for Medical Oncology (ESMO)
American Society of Clinical Oncology (ASCO)
Australasian Gastro-intestinal Trials Group (AGITG)
Breast Cancer Trials Group (BCT)
Australia New Zealand Gynaecological Oncology Group (ANZGOG)

North Lakes Haematology and Oncology Clinic P: 07 **3859 0690** W: **nlhoc.com.au**

Dr Sharon Heng

MEDICAL ONCOLOGIST AND PALLIATIVE CARE PHYSICIAN
MD, FRACP (Med Onc), FAChPM

MORETON BAY
CANCER CARE

PRACTICE LOCATIONS

North Lakes Day Hospital
7, Endeavour Boulevard,
North Lakes, QLD 4509

Morayfield Health Hub
19-31, Dickson Road,
Morayfield, QLD 4506

Moreton Bay Cancer Care P: 07 **3859 0690** F: 07 **3491 3614** W: **moretonbaycancercare.com.au**

AHPRA INVESTIGATES by Dr Mal Mohanlal

Have you ever been investigated by AHPRA (Australian Health Practitioner Regulation Agency)? Are you under investigation now? If you are, here is how you go about turning your negative experience into a positive one.

Remember AHPRA is a bureaucratic body created by the government to regulate the medical profession. As such, you must understand that people who run this body are limited by the rules and regulation set by the government. That is they are not allowed to think for themselves. They go by the letter of the law. Hence please do not be surprised if at times you think you are dealing with zombies. So when a person lodges a complaint against a doctor AHPRA is obliged to investigate.

Recently a patient who I saw for the first time requested a referral to see a psychologist. Since before such referral, a proper assessment had to be made and a Mental Health Care Plan prepared, I counselled her on this occasion and asked her to see me the following week. She did not see me the next week but saw her regular doctor who prepared the Plan and referred her to the psychologist. She then lodges a complaint against me with AHPRA that I refused to refer her to a psychologist when she saw me for the first time. Thus I became a subject of AHPRA investigation.

Imagine my shock and surprise when I received the letter from AHPRA saying: "Notification we have received about your performance" and "the Board has raised the following questions for consideration:

1) Whether you exercised good patient care in providing Ms… with a referral to a psychologist.
2) Whether you acknowledged and respected the contribution psychologists and counsellors may have in the care of Ms… in your conversation with her on ..date..
3) Whether you exercised good patient care in listening to Ms… 's concerns during her consultation with you on .. date…
4) Whether you appropriately recommended honest and transparent in declaring your financial interest when recommending your book "The Enchanted Time Traveller."

The tone of the letter instantly made me sick. It was an assault on my integrity and honesty. It had bullying and intimidating tone. It made me feel that I had committed a serious offence and was some criminal. It was demeaning and humiliating. It was devaluing my worth. Not only that, but it implied that I was considered guilty until proven otherwise.

I answered these concerns in my letter to AHPRA in November 2018. No word was heard from them until April this year when I received another letter from AHPRA advising me that the matter needed further consideration and more information was required. This time they added a 5th clause stating:

"5)Whether Dr Mohanlal's clinical records for Ms… including progress notes for the consultation on ..date.. at the Practice were inadequate and/or inappropriate."

They listed six more questions for me to answer. It was insulting because they made out as if I did not know much about the practice of medicine. By this time I was beginning to think that this was becoming a witch hunt, as I felt they were trying to convict me. But I responded politely as best I could, knowing all the time I had not done anything wrong.

Then about three weeks later AHPRA sends me a five-page mind-boggling report advising me that they have decided not to take any further action.

Fortunately for me, that I have some self-knowledge and understand how ***Continued Page 15***

AHPRA INVESTIGATES continued

my subconscious mind operates. Hence I was quickly able to resolve these negative feelings inside me and normally live without much further thought in spite of months of investigation. But in any other individual without any self-knowledge, I could see that it could have led to anxiety, depression, stress and all sorts of problems.

All negative or positive feelings arise in our subconscious mind. One must never live with a negative feeling. It will stop you from enjoying life. Therefore, my advice to all the doctors facing this type of situation is to acquire some self-knowledge and an understanding of how your subconscious mind operates, and take the following steps:

Firstly, clear up your perceptions about the people and the mentality you are dealing with. See my description above.

Secondly, you take a good look at yourself and who you are. Realise that you are a doctor and a clinician, not a bureaucrat. Be proud of that fact. Do not let a bureaucrat tell you how to practise medicine. Think like a doctor, not a bureaucrat. You do not have to fear anything if you have not done anything wrong. If you have made a mistake don't be afraid to admit your mistake and apologise. Be honest with yourself.

Then become aware of all the negative feelings you have. Do not analyse them but say this in your mind: "No miserable person is going to make me miserable. No miserable person is going to put me down." Invent your own phrases if you like, and repeat them from time whenever you feel the miserable cloud hanging over your head. I can assure you that before long your subconscious mind will have resolved the problem for you. It will be viewed from a different perspective, and you will not experience any distress at all. You do not have to believe what I say. Try it and tell me all about it. You can get rid of that cloud hanging over your head very quickly.

Please remember, AHPRA has a thankless and challenging job to do. For most of the time they are dealing with complaints from people who have mental health problems. Surely there must be a better way of handling these complaints instead of traumatising the hard working doctors. I felt sorry for the person who wrote that brilliant five-page report on me. What a waste of energy, resources and talent, I thought.

In the Brisbane Courier-Mail of 7 May 2019, there was a report titled "Music legend felt 'violated'". Diana Ross "was close to tears as a security officer felt between her legs during an airport pat-down". "I was treated like s..t". "Makes me want to cry." "It's not what was done, but how," she insisted. "However, a TSA spokesman said that CCTV footage appeared to show the officers involved 'correctly' followed all protocols".

Yes AHPRA, it is not what you do, but how you do it, that bugs us. Is this how one should go about exercising one's authority?

Read "The Enchanted Time Traveller – A Book of Self-knowledge and the Subconscious Mind". Visit Website: http://theenchantedtimetraveller.com.au/

The Qld Palliative Care Spirituality Group

Friday
26th July 2019
8:30am – 4:30pm
Registration from 8:00am

Garden Marque
Victoria Park Function Venue
261 Herston Road
Herston

Registrations close: Friday 12 July 2019

Contacts:

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suecolen@gmail.com
0417 713 930

Dr Judith McEniery
jmc19161@bigpond.net.au
0407 744 338

Dimensions of Palliative Care- Exploring the Spiritual

Target Audience:
Health Professionals of all disciplines are invited to register to attend.

Objective:
To build on existing knowledge and practice in provision of spiritual support for those receiving Palliative Care.
To inspire practitioners to offer their humanity along with their knowledge and experience to those in their care.

Previous Participants' Feedback:

"A highly energised forum where we were invited and inspired to 'go deeper' in our palliative care practice."

"Thought-provoking education day focusing on numerus aspects of spirituality and palliative care. Clear practical skills I can immediately apply to my clinical practice. You won't be disappointed."

Registration: $125

(Early Bird Booking by 14/06/2019 - $115)

Includes Morning tea, Lunch and Closing drinks.

Free parking available on site.

Please register on-line at:
https://explorethespiritual.eventbrite.com.au

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The Argument Against Proposed Euthanasia Legislation In Queensland
Dr Judith McEniery, Palliative Care Specialist

The move towards euthanasia/physician assisted suicide has huge implications for each one of us and for society in general. Do we really want this option so directly involving doctors in the taking of life?

What I have found in 25 years as a Palliative Care doctor is that people facing death desperately want and need doctors and nurses to provide meticulous care and comfort. On the whole, patients wish to continue measures with even a vague chance of improving their condition. Asking doctors to turn from this to instead directly and intentionally ending patients lives changes the face of the medical profession from caring advocacy to collusion in suicide. This is a drastic and dangerous deviation.

One of the common myths about Palliative Care is that it deals only with the very end of life- final days or hours. As people live longer with illnesses once considered death sentences (for example, metastatic melanoma and breast cancer), connection with Palliative Care may be beneficial throughout an illness, even 'on and off' as pain and other issues wax and wane. Another common myth is that using strong pain relief shortens life, whereas studies show that the opposite can occur. It is also vital to point out that withholding or ceasing active interventions including artificial feeding and fluids as death approaches is acceptable medical practice and is not euthanasia.

I feel very strongly that those wishing for the 'right' to intentionally end their own lives, or of their relative or loved one, have stolen the term 'dignity in dying'! Providing dignity in the dying process has been the focus of Palliative Care for decades. The other theft has been of the term 'medical aid in dying', used frequently overseas regarding euthanasia legislation similar to that proposed in Queensland. Palliative Medicine Specialists are the experts in medical care of the terminally ill, applying detailed knowledge to give excellent management of distressing symptoms such as pain, nausea, breathlessness and other concerns.

I quote Dr Natasha Michael, a Melbourne Palliative Care physician when I speak of three groups of patients who ask about assisted dying. Firstly, there are those who say "I want to die", and it is important to explore with these patients the reasons behind their distress. When concerns are discussed and attended to, the wish for a hastening of death usually resolves. The second group is those who say "let me die". Often, these patients are very ill and tired of life, and may already be approaching the terminal phase of illness. It is very reasonable for them to forego further active measures. It is the third group who say "kill me" who are seeking euthanasia/assisted suicide for a variety of reasons. The concern is that these three groups are viewed together. So often when euthanasia is raised, this is done by distressed family members, sometimes lacking awareness of what the normal dying process is like.

When my own dear father died in 1986, there were no available slow release opioids in Australia, and the discipline of Palliative Care was virtually unknown. His suffering was significant. Since then, many highly effective medications have become available, usable in hospitals, homes and Aged Care Facilities, and continually improving. Unfortunately, for many doctors, learning to use these has been challenging. In modern medical schools, teaching of Palliative Care is minimal, and familiarity with death and dying almost ignored. This of course is echoed in the general population. In the past, everyone had contact with death by the time they had reached adulthood.

Pain can be challenging to manage especially when accompanied by other distress and fears- for example of losing one's role as carer or provider, of being a burden, of being alone and unloved. In my experience, most requests for euthanasia come not from those in severe pain, but from those who fear being a burden to others.

Very severe pain can be difficult to control, and may need expert use of strong pain relief combined with other measures including sedation. This is most often warranted when a person is close to death with distressing symptoms and perhaps unresolved psychological issues, but without time or strength to deal with these.

Overall, like every aspect of health care in recent times, Palliative Care has progressed in expertise to assist those facing serious illness and death. Many times those requesting euthanasia quite rightly feel they can bear no more. These patients may be actively dying, but they and their families have not been gently and expertly been made aware of this. Our society needs increased familiarity with dying as part of life, and of the language and features of what a 'good death' entails. Focus on this awareness and the availability of excellent Palliative Care can transform experiences of death and dying in a far more loving and humane way than euthanasia. A drastic injection of effort and funds to Palliative Care services and for education of doctors, nurses and other health personnel is urgently needed.

Dr Sharon Heng
MEDICAL ONCOLOGIST AND PALLIATIVE CARE PHYSICIAN
MD, FRACP (Med Onc), FAChPM

MORETON BAY CANCER CARE

Immunotherapy: In a nutshell

The Father of immunotherapy, William B. Coley, when he first injected bacteria into his cancer patients in the late 19th century would have never thought that immunotherapy would transform the treatment of cancer.

In 2011, a CTLA-4 inhibitor, ipilimumab (Yervoy) was approved for metastatic melanoma and since then, PD-1 inhibitors; pembrolizumab (Keytruda) and nivolumab (Opdivo) and PD-L1 inhibitors; atezolizumab (Tecentriq), avelumab (Bavencio) and Durvalumab (Imfinzi) have been approved for multiple cancers including lung, renal, bladder and head and neck cancers. These checkpoint inhibitors or monoclonal antibodies are often referred to as the popular 'immunotherapy'.

Why is this important for General Practitioners?

Immunotherapy is currently widely used in patients with advanced melanoma and lung cancer which are two of the top five most common cancers in Australia (the others being breast, prostate and colorectal cancer). The indications for immunotherapy are also expanding rapidly as pharmaceutical companies race to find evidence for its effectiveness in other cancers. It is very likely that most, if not all General Practitioners (GPs), will have patients on their books that are on immunotherapy.

Furthermore, with public oncology departments stretched by ever-rising demand for their services, there is a push for a 'shared care' team approach. This implies a model of care with earlier engagement of GPs as part of the cancer team which would be beneficial for GPs as they can sometimes be left out of the loop whilst their patients are undergoing active treatment.

What do you need to know?

While immunotherapy works only in some patients, it has led to durable responses and significant improvements in overall survival in cancers which previously had very poor prognoses.

Used as a single agent, checkpoint inhibitors are generally well-tolerated. Though theoretically, immunotherapy could adversely affect any organ, the most common side effects are diarrhea, fatigue, rash, nausea and hypothyroidism which are easily managed. Some patients (10-20%) sustain severe side effects from monotherapy and this need to be considered in all patients who present with complaints.

Unfortunately, combination immunotherapy (e.g nivolumab/ipilimumab) which is increasingly being used in melanoma and other cancers puts patients at a significantly higher risk of severe side effects. In studies, more than half (55%) of patients on the combination of nivolumab/ipilimumab exhibited severe side effects. Considerably more patients can have colitis, hepatitis, pneumonitis, nephritis and pyrexia which can be potentially life-threatening if not treated early. Patients with suspected side effects from combination therapy should ideally be referred urgently to the oncology team for early investigation and intervention.

Checkpoint inhibitors are believed to be cleared from the system via catabolic pathways in the same manner as endogenous antibodies. As this does not involve cytochrome P450 or other drug metabolizing enzymes, no major drug interactions are expected. However, due to how these treatments exert their effects by stimulating the immune system, it is recommended that patients not have steroids or at least receive the lowest dose possible, preferably no greater than 10 mg of prednisolone (or equivalent) per day.

Patients with auto-immune conditions are at risk of flare-up of their disease with immunotherapy. Unfortunately, it can be complicated to balance treatment for both the auto-immune disease and cancer. These patients are usually managed by multiple teams which often include oncologists, rheumatologists and gastroenterologists.

Whether or not patients on immunotherapy can receive routine vaccinations is another question GPs may frequently ask themselves. There are no formal studies to evaluate vaccines in this patient population. However with the flu shot, the consensus is that it is safe to receive it during treatment with PD-1 inhibitors (pembrolizumab, nivolumab) and PD-L1 inhibitors (avelumab, durvalumab). Patients receiving CTLA-4 inhibitors such as ipilimumab should wait at least 6-8 weeks after the last dose. Live vaccines should not be given during treatment with immunotherapy and for at least 6 months afterwards. In any case, live vaccines should not be given in patients who have poorly controlled cancer.

What does the future hold?

Various combinations of monoclonal antibodies, small molecule protein inhibitors and chemotherapy are being trialed in almost every cancer and new drugs are rapidly being developed. Issues moving forward include elucidating the cost-benefit ratio of these new treatments, better patient selection and evaluating the long-term toxicities of immunotherapy.

The challenges are manifold but the goal of 'curing' cancer is a worthy one to aim for. If we ever do succeed it is likely to be the result of a combination of approaches. Immunotherapy in its various forms will no doubt be the future of cancer care. Right now, we are just scratching the surface.

Moreton Bay Cancer Care P: 07 **3859 0690** F: 07 **3491 3614** W: **moretonbaycancercare.com.au**

Bhutan
"Land of the Dragon"
by Cheryl Ryan

Bhutan has always bee considered one of the happiest countries in the world and after a recent visit I can see why.

A spiritual haven for Buddhists surrounded with temples and monasteries. The famous Tigers Nest Monastery sits some 3140m above Paro and the return climb up will take you around 5-6 hours. A spectacular hike with a café mid-point for a well-earned rest and cuppa.

Around 300 people per day do the hike up and back and they range from families with young children to the elderly.

I started the hike around 7.30am in the morning and opted for a horse ride for the first sector so I could sit back and enjoy the view – which is spectacular.

Along the way you pass through a forest of Blue Pines and Rhododendron's. Upon reaching the café I then continued the slow hike upward on foot. The trail winds up and down and there are plenty of viewing spots to stop along the way.

As we get close to the top the monastery it appears to be clinging to the edge of the cliff and you realise why the locals believe that the Lama, Guru Rinpoche, rode in on a Tigress' back to subdue a local demon.

It was with the assistance of some magic that Taktshang Goemba Monastery around the 8th Century was constructed. It was blessed and sanctified as one of Bhutan's most religious sacred sites.

I was starting to be a believer!
I am looking forward to being back in Bhutan again in November to explore a little more of this amazing country.

Need to Know:
• Tourists can enter the monastery as per these timings as long as your guide has arranged the standard permit in advance:
 Camera and Photography is not allowed inside the monastery.
 Bhutan has strict entry conditions and you must travel with a tour or guide when visiting.

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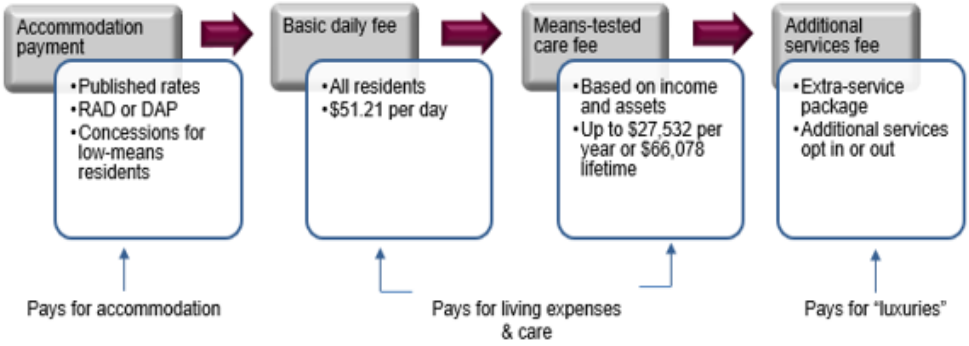
LET'S LOOK AT SELF-FUNDED RETIRES AND THE COST OF AGED CARE…..

We all know that older Australians, given the choice, prefer to stay at home rather than move into an aged care facility. On a weekly basis I am astounded at the amount of self-funded retirees who will shy away from putting their hand in their pocket to pay for home help. They are often in their frailty years and at high risk of a life changing event which may dictate full-time care requirements. Yet they struggle through each day in an effort to preserve the bank balance. Often this resistance to pay for home help unknowingly contributes to their decline and eventually the choice to move into full-time care is no longer an option but rather a requirement.

Over this article and the next 2 articles we will be looking at aged care costs for self-funded retirees. It is important to remember that every person's situation is different however we will be using real working examples to demonstrate the cost of aged care. We will compare full-time care in a facility, followed by home care packages and lastly full-time care at home. Now, I don't have a crystal ball and I can't guarantee that additional home help will keep a person out of an aged care facility. However, if a self-funded retiree were to understand the costs of full-time care, they may be more inclined to reach into their pocket to fund help. This will give them the best chance to stay at home longer and maybe, just maybe, avoid full time care altogether. Now let's look at the very real cost of full-time care in a facility, for a self-funded retiree. There are four fees payable when you move into aged care as listed below.



Accommodation can be paid as either a refundable accommodation deposit (RAD) or a daily accommodation payment (DAP) or a mixture of both. For example, a RAD of $550,000 can be converted to a DAP of $89.81 per day at the current interest rate of 5.96% per annum. For the purpose of this article we will use an accommodation payment of $550,000 along with an additional services fee of $25 per day and the annual means-tested cap of $27,532. This is a very realistic scenario for a fully self-funded retiree on the Sunshine Coast. As you can see from the below figures significate out-of-pocket expenses are incurred when funding full time care in a facility.

Aged care fees (per annum)	Accommodation paid as a DAP	Accommodation paid as a RAD
Basic daily fee	18,692	18,692
Means-tested care fee	27,533	27,533
Additional services fee	9,125	9,125
DAP	32,780	0
Total aged care fees	**$88,130**	**$55,350**

In our next article we will look at the cost of home-care for self-funded retirees along with an example of how much care can be purchased if a person was to spend $88,130 or $55,350 on care to stay at home.
If you have any questions feel free to call me on 07 54379900.

Article Written by Sharon Coleman. Accredited Aged Care Specialist / Accountant.

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OVERWORKED RURAL DOCTORS CALL FOR MORE STAFF AND WORKABLE ROSTERS – AMA SURVEY

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Rural doctors around the nation are crying out for an urgent investment in funding and resources to improve staff levels and hospital facilities in the struggling rural health system, a new survey has found.The AMA Rural Health Issues Survey 2019 found that more staff and workable rosters was the most critical priority for improving rural health outcomes as rated by rural doctors, unchanged since the last survey in 2016. That was followed closely by more trainee doctors in rural areas, and the need for modern hospital facilities and equipment. "These survey results paint a picture of a struggling system being held together by hardworking and dedicated doctors," AMA President, Dr Tony Bartone, said today.

"All of the groups surveyed – GPs, non-GP specialists, salaried doctors, doctors in training, and other medical professionals – identified extra funding and resources for staff, including core visiting medical officers (VMOs), to allow workable rosters as their top priority. "This reflects rural doctors' long-held concerns about the lack of staffing in rural hospitals, the high workload, and the significant levels of responsibility placed on hospital doctors and VMOs.

"Poorly-designed rosters and staff shortages lead to fatigue, and doctors in training often have a significant burden of responsibility placed on them in rural hospitals. "It's not surprising that the survey results have barely changed since the last AMA Rural Health Issues Survey in 2016 – because the conditions in rural and remote Australia have barely changed. "While there have been some positive developments as a result of the 2016 survey, the impact of these initiatives will not be felt in rural communities for years. "What is surprising is that rural health has received very little attention from any of the major parties during this Federal election campaign.

"The promised roll out of the National Rural Generalist Pathway by the Coalition is a welcome move and the ALP has committed to developing a National Rural Health Strategy. However, rural communities are looking for something more immediate. "It remains inconceivable that millions of Australians who experience higher incidence of the drivers of chronic disease are being overlooked. "Australians who live in rural and remote areas cities have poorer health outcomes than those who live in cities. They access Medicare at far lower rates than city dwellers, and wait longer to see their GP. "Rural communities have fewer doctors and are finding it increasingly difficult to attract new ones. "Rural doctors are up against it, and it feels like no-one is paying attention."The AMA is calling for immediate funding to improve infrastructure, and to support more doctors to build their lives and careers in rural areas.

"One of the most encouraging outcomes of the Survey is the overwhelming satisfaction that rural doctors gain from their work. "Rural doctors enjoy treating generations of families, feeling involved in their communities, and tackling a wide range of health conditions. "Rural doctors love their work – they just need more support to keep doing it. "It will be up to whoever wins Saturday's election to ensure that rural doctors and their communities do not continue to be overlooked." The AMA Rural Health Issues Survey 2019 is available at https://ama.com.au/2019-ama-rural-health-issues-survey

Background

- The AMA Rural Health Issues Survey of more than 600 rural doctors was conducted during March 2019.
- Survey participants were asked to rate the importance of 31 different proposals, and to provide additional comments or suggestions.
- Rural GPs were the largest group of respondents (32.6 per cent), followed by non-GP specialists in private practice, salaried doctors (17.4 per cent), other doctors including rural generalists, locums and VMOs (16.6 per cent) and doctors in training (14.1 per cent).
- The majority of responders were from New South Wales (30.5 per cent), followed by Queensland (26.1 per cent), Victoria (22.9 per cent), Western Australia (8.4 per cent), Tasmania (6.8 per cent), South Australia (4.2 per cent), Northern Territory (1 per cent), and the ACT (0.2 per cent).

16 May 2019

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R. Brown

Dr Bob Brown

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