RDMA
RDMA & NLMA's Joint Newsletter

Newsletter
NOVEMBER 2018

"Rembering Ernest Albert Cory"
From Wikipedia, the free encyclopedia https://en.wikipedia.org/wiki/Ernest_Corey

President's Report Dr Kimberley Bondeson

The silly season is nearly upon us, the time having seemed to have gone incredibly fast. We are still experiencing warm days and cooler nights; the full summer heat has not yet hit us.

Mandatory reporting changes is currently before parliament and it is disappointing in what has been put forth. Doctors have requested that the current mandatory reporting in Queensland and other states be the same as Western Australia, which is exempt from Mandatory Reporting laws. Doctors from all other states are travelling to Western Australia to seek treatment, in fear of losing their medical registration and livelihoods. Such a situation should not exist.

The current nation's health ministers have put together legislation to change the current mandatory reporting laws. Unfortunately, they have not listened to the medical profession. Under proposed changes, treating practitioners will not be required to report if their patients' issues are being managed through treatment.

However, they still have to report behaviour such as practising whilst intoxicated or departing from professional standards if they believe the conduct places the public at "a significant risk of harm". The exception will be cases where a doctor has engaged or is likely to engage in sexual misconduct. In these cases, the treating doctor will be required to report. (Australian Doctor, November, 2018). There is a mixed reaction to these proposed changes. How it all unfolds remains to be seen. In the meantime, practitioners who are seeking treatment, will continue to fly to Western Australia.

The My Health Record (MHR) is still struggling. Privacy is a continuing issue, and the Federal Minister, Greg Hunt, has just extended the opt out time line, which was announced the following morning after the MHR website crashed on the initial final opt out date. Too many users were attempting to opt out. One of the new concerns, is that parents currently have default access to the records of teenagers aged between 14-17 years old. Minister Greg Hunt is also promising to change the law so that parents subject to an apprehended violence orders will no longer be able to maintain control of their child's record. I have no doubt that this is going to be incredibly difficult to police, and opens up a can of worms in terms of child protection from abusive and dangerous parents, who will be able to track the whereabouts of their children from their MHR.

Seasons' Greetings to everyone and have a lovely Christmas and New Year!

Make sure you enjoy the RDMA End of Year Networking function, on Friday December 7th, at the Golden Ox. The following Friday, the 14th December, is the North Side LMA End of Year Function, so hope to see some of you at both meetings.

Kimberley

RDMA & NLMA's Joint Newsletter
Welcome from
Dr Robert (Bob) Brown
President Northside Local Medical Association

Note: Doctors in Training RDMA Membership is Free
RDMA 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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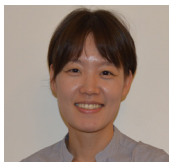

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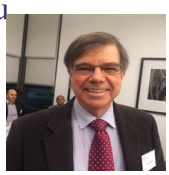

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RDMA 2018 MEETING DATES:

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	27th
Wednesday	March	28th
Tuesday	April	24th
Wednesday	May	30th
Tuesday	June	26th
Wednesday	July	25th
ANNUAL GENERAL MEETING - AGM		
Tuesday	August	28th
Wednesday	September	12th
Tuesday	October	30th
NETWORKING MEETING		
Friday	December	7th

NEWSLETTERDEADLINE

Advertising & Contribution 16th December 2018

Email: RDMANews@gmail.com

W:www.redcliffedoctorsmedicalassociation.org

NLMA 2018 MEETING DATES:

For all queries contact Graham McNally Meeting Convener: Phone: (07) 3121 4029
Email: gmcnally1@optushome.com.au

W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants

Time: 6.45 pm for 7.15 pm

1	February	13th
2	April	10th
3	June	12th
ANNUAL GENERAL MEETING - AGM		
4	August	14th
5	October	9th
6	December	14th

Next Meeting Date 7th December 2018

RDMA October Meeting for 30.10.18.

Dr Herdy RDMA Vice President Introduced the two Speakers:

Guest Speaker
Dr Dilip Duhpelia, President of AMAQ and Dr Michael Cleary Vice President AMAQ

Speaker
DrAndreas Fiene, Respiratory & Sleep Medicine Physiccian & Lung Transplant Physician, North Brisbane Sleep & Thoracic , North Lakes
Topic "Treatment Options for Severe Emphysaema: Engobronchial Valves, Surgical Lung Vollume REduction and Lung Transplantation".
Sponsor: Pulmonx Inc, Ben Hack representative.

Photos (Left to Right):
Speaker
Dr Andreas Fiene
Speakers & Sponsor Representative:
Dr Michael Cleary, Ben Hack, Dr Dilip Duhpelia, Dr Andreas Fiene and Dr Wayne Herdy.
Dr Andreas Fiene & Dr Wayne Herdy.

Christmas Party

Redcliffe & District Medical Association Inc.

DATE: **Friday 7th December 2018**

TIME: 7.00pm for 7.30pm start

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

COST: Members Free of charge, Members' partners $60
Non-members $60, Non-members' partners $100

DRESS: Smart Evening Wear

SPONSOR: Redcliffe & District Medical Association Inc.
The Golden Ox

DETAILS: 7:00pm - Arrival and Registration
7:30pm - Entrée served
Welcome by Dr Kimberley Bondeson - President RDMA Inc.
8:15pm - Main Meal
8:40pm - General Business, Dessert, Tea & Coffee

RSVP: By Monday 3rd December 2018
(e) RDMA@qml.com.au or 0466 480 315

Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology PUB/MR/1330, version 1 (Jan-16)

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INSIDE THIS ISSUE:

Competitive Advertising Rates:

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Advertorials: $260.00
Inserts: $260.00

The preferred A5 size is Landscape Format. and A4 size is in Portrait Format.

Please note the following discounts:

- **10% discount for 3 or more placements**
- **20% discount for 11 placements (1 year)**
- **Payments required within 10 working days or discounts will be removed unless a payment plan is outlined at the outset.**

CLASSIFIEDS

All classifieds subject to the Editor's discretion.

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

If you would like to advertise in the next month's newsletter please email RDMAnews@gmail.com in one of the preferred formats (either a pdf or jpeg). Advertisers' complimentary articles must be in the same size as adverts. Members Articles are limited to an A4 page with approximately 800 words.

AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

Gambling Addiction and Staged Dosing

GAMBLING ADDICTION.
One of the more disturbing phenomena that we observe today is the meteoric rise in media advertising of bookmakers and gambling. Some offer incentives that sound too good to be true, which usually means that they are.

Everybody knows that providers of gambling services, whether bookmakers or poker machines or Lotto, have a clear business model. A percentage of the income is returned to the punter and the rest is administrative costs and profit. Pokies can be programmed to return predetermined percentages. Lotto has an approved percentage. The figures are typically around 50% of the gross take being returned to the investor. Bookmakers' profit margins have historically been less than that, so it is curious that the larger players can now offer incentives and still count on a profit. A bookie's profit margin is pre-calculated, because the odds are offered to produce a known return. For the modern bookmaker, as for the time-honoured totaliser, the profit margin is no gamble.

Addictions take all shapes and sizes. Gambling addiction is a silent epidemic. It is often difficult to identify because it is seen as a game and as central to the funding of some sports. Not-for-profit organizations rely on raffles as a mainstay of fund-raising [how many citizens disapprove strongly of the Mater or Endeavour prize homes?] Gambling is seen as harmless fun. It is not harmless. Gambling addicts have been well known to lose far more than they can afford. Hence the signs in the toilets in casinos, and the little rider at the end of the TV ads: "Remember, gamble responsibly". How do you conduct an irresponsible activity responsibly? "Responsible gambling" for some people is like risk-free mountain-climbing. Even harmless fun can be damaging. I had a patient, a little old lady, whose losses at bingo were so great that she could not pay her rent or buy groceries. She was placed under financial administration so her rent and grocery bills were quarantined. Bingo!

The AMA lobbied to have tobacco advertising progressively removed from public media, starting with prime time TV when children were viewing. There are limitations on alcohol advertising – we do not see alcohol advertising closely associated with motor sports. These examples should be taken as a model of the medical profession's approach to gambling advertising. If it causes physical, psychological or social harm, doctors have a role in minimising the harm.

Footnote: can we ever apply this same logic to advertising that feeds shopping addiction??

STAGED DOSING.
Some patients cannot be trusted to manage their own medications, especially substances of abuse such as opiates and benzodiazepines. Addiction specialists are almost as concerned about Seroquel and Lyrica, two commonly-prescribed and supposedly non-addictive drugs which are known by the drug-using subculture to have mind-changing effects which give them a street value.

When we recognize that a patient is misusing or over-using prescribed substances of concern to us, one of the strategies open to us is staged dosing. We can endorse the prescription to require the pharmacist to dispense the medicine weekly, twice-weekly, or even daily, and in the most troubling cases can endorse the prescription for the pharmacist to observe the dosing.

Pharmacists are interested in medication safety and are generally prepared to do this. But at a cost – to the patient. Typical costs are $5-$15 per week, or sometimes $5 per dose in the case of daily dosing. This is actually a very moderate charge, considering the time taken for a health professional to perform the task and keep it accurately documented. Patients hate it, more because of the cost than because of the inconvenience and slur on their reputation. Patients put on staged dosing know that they have done wrong and are mostly prepared to wear it in order to maintain their supply of their chosen medication.

There is a partial solution available to some patients. The federal government has made available a special payment to pharmacists to cover the additional charge for staged dosing. But only to a maximum of 15 patients (per pharmacist or per pharmacy? Sorry, I am not sure). So if you want to impose staged dosing on a miscreant patient, one of the obstacles to medication safety has been partly eliminated.

The views expressed herein are those of your correspondent,
Wayne Herdy

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Members Update

Professor Steve Robeson's story, entitled "This is my story, so let's talk about it" as seen in the Medical Journal of Australia is unique. I

t is an honest description of the hell he went through as a junior doctor 30 years ago in the Central Queensland town of Rockhampton.

My sister works there as a Registered Nurse. She told me the story of the lovely junior doctor, Frith Footitt, who took his own life earlier this year. He left behind a wife and 4 young children. It is real.

We have suicide and depression, along with mental illness amongst the medical profession. And for some bizarre reason, this appears to be unacceptable, and seeking treatment in Australia and in all states except Western Australia has a strong likelihood of resulting in losing the practitioners' registration.

This mandatory reporting needs to be changed. How many more deaths do we need to see before it is done properly? The current changes are only half way towards assisting those medical practitioners who need it.

There is a move at this time by the Health Ministers to force doctors to disclose details of negligence settlements to the Medical Board of Australia. It is suggested changing the National Law so that all registered health practitioners were required to report "details, including amounts, or any professional negligence settlements or judgements against them" (Australian Doctor, November 2018).

It goes on to offer other options, including notifying the medical board of any previous negligence settlements only in cases when the doctors were being subject to a disciplinary process.

According to Australian Doctor, this proposal also followed the Medical Board of Australia's plan to target "high risk" doctors, which includes those practising in isolation from peers, and those over 70yo. The AMA is concerned this will destroy trust between doctors and their medical defence organisations, and I support this.

No wonder Australia has difficulty in getting doctors into rural areas. And the government is working towards discouraging medical practitioners from working after the age of 70yo. One article in Australian Doctor is entitled "Wanted: a 'Unicorn' for Woop-Woop Town", referring to the requirement by the Medical Board of Australia's restrictions in 2016 to improve the supervision of IMG's on limited registration working in isolated communities.

They must be supervised in their practice by a GP with at least 3 years' post-fellowship experience. This could be in a town that would not be able to support 2 doctors, let alone bulk billing. I believe that not only IGM's will find this difficult, but also any local Australian Graduates will not be willing to do this, due to isolation, lack of support, and low remuneration.

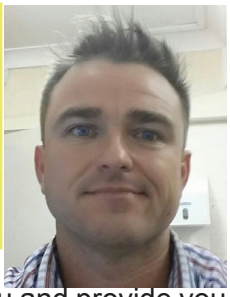
These changes, and other proposed changes supposedly under the guise of documents like the health council's proposal "Regulation of Australia's Health Professions: Keeping the National Law Up To Date and Fit For Purpose", July 2018 (Australian Doctor) seems to be having a negative effect on the recruitment and retention of doctors, and a disincentive to even undertaking a medical degree, and which seems to be increasing.

Kimberley Bondeson

A Personal Call To Action From: Benjamin "Ben" Sibley Owner of new Podiatry Business … Your Podiatrist Brisbane

https://www.yourpodiatristbrisbane.com. PH: 30400230/ 54956437
EM: info@yourpodiatristbrisbane.com. FAX: 54956336.

REDCLIFFE: 88 Sutton Street. Redcliffe 4020
MORAYFIELD: 5/85 Michael Avenue. Morayfield. 4506
RUNCORN: 961 Beenleigh Road. Runcorn. 4113



Attention!! All Doctors Who Refer To Podiatrists For Foot Pain, Heel Pain, Plantar Fasciitis and Orthotics!"
"Why I Am offering Your Patients A Free Gait Assessment With Their First Appointment"

Dear Doctors,
Hi! If we haven't met then please let me introduce myself. My name is Ben Sibley and I'm the new owner and practicing Podiatrist of **Your Podiatrist Brisbane -Redcliffe** and Your Comfort Shoes.

Can We Talk?
I hope you'll excuse me for being blunt, but there's some things I want to address with you off the bat. When I decided to start ***Your Podiatrist Brisbane – Redcliffe*** a little over 18 months ago I realised I had my work cut out for me, more than usual.

Why?
Well you see there are quite a few Podiatrists practicing in the area and I've heard that some Podiatrists may not be addressing some of your basic professional needs …

- Regular communications with yourselves about your patients care
- Writing back letters after you have sent referrals !!!
- Letting you know if your patients haven't been happy with Podiatry service and what we have done to help them.
- LookingafterallyourDVApatientswithcustomfootwear-
- Giving your patients full money back guarantees on orthotics if the orthotics happen not to work for them. (And I can tell you after 24 years of using orthotics …sometimes they don't work!!!)

Some of you may be feeling a little bit taken for granted and not feeling valued as the primary care facilitator for all your patients health requirements which as you know is a huge and important responsibility. You see what I have discovered is that most of you is you want reliable consistent Podiatry services that patients can access that is either bulk billed (EPC and DVA bulk billed with no gaps) and pricing that is reasonable and not too far out of your patients reach.

You want regular communication and at least, a letter sent back when you refer a new patients and EPC patients. You see what I know is that most Podiatrists get so busy and lazy and don't send letters back. To me that communicates complacency and they don't value you, your time and effort. Your referrals are the lifeblood of any allied health business and must be taken care of and nurtured end of story!! Your Referrals Are Appreciated and Respected. So you now can see my dilemma! Lots of competition, professionals out there like yourself maybe feeling indifferent at not getting the Podiatry Service you should expect and maybe not feeling valued!

So as the "new guy" in town I have to do what I can to assure you those unmet needs get met. I want to develop a great relationship with you and provide you and your patients with a high standard of care, foot and ankle pain relief for your patients and custom comfortable orthotics and footwear. I have a very simple offer that I hope you'll take advantage of …

Here's $97 To Use Either Towards Your Patient's Initial Gait and Posture Assessment or Towards Their Custom Foot Orthotics … your choice!

The very best way to see if I am worthy to be your Podiatrist and orthotic provider is to try me at my own expense. So please accept this $97 gift certificate for you and your patients and come on in and give us a try. If after your patients first visit they decide that where not the one of the best in Brisbane and Redcliffe area then we'll part friends with no hard feelings.

Why You Should Give Us A Try?
1. Firstly, I'm not an absentee owner, part-time bitsa Podiatrist clinic or part of a bigger Podiatry chain with a large revolving door of "podiatrists" where you may not know who will be your next Podiatrist.
2. You will always know and receive personalised care, the latest up to date technology in gait and posture assessment and computerised comfort orthotics.
3. I have been a Podiatrist now for 24 years and this is my business and livelihood and my profession. I realise that my reputation as a business owner and as a Podiatrist is on the line with every client that you refer. So if your unhappy with our office, I take it personally … I'll do whatever it takes to make it right and earn the referrals from you and your co-workers.
4. In fact I am so serious about our office and the service, products and orthotics I deliver to you with great results that I give your patients this guarantee in writing.

Come On In and YOU Be The Judge
I could go on about the things I have done and my credentials and experience but frankly this isn't about me. It's about YOU having confidence and trust in me. Trusting that you're getting the best Podiatry Service in Redcliffe. And you can't build trust and confidence on paper … it has to be done in person wouldn't you agree?
Thanks for reading this letter. I look forward to meeting you soon.
Kindest regards, Ben Sibley

P.S. Your $97 can be used for Gait Assessment and or Orthotic Assessment. **Call our office on 30400230,** leave your first name, last name, email address, and practice address and for a referral pad/ USB.

Alternatively if you want to book your patient in …. go directly online to http://yourpodiatristbrisbane.cliniko.com/bookings and book an Orthotic Assessment or Gait Assessment appointment.
Kindest Regards Ben

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

AMA Queensland to fight against Pharmacy Inquiry recommendations
AMA Queensland has formed a working group, which will devise a strategy to push back against the Queensland Parliament's Health Committee reports' recommendations.

AMA Queensland is deeply concerned with the recommendations, which include allowing pharmacists who give out low-emergency and repeat prescriptions, allowing community pharmacy assistants to handle dangerous drugs, and setting up a Pharmacy Advisory Council without the expertise of a doctor.

The AMA Queensland working group will work closely with both the Federal AMA and the medical colleges with the ultimate aim of ensuring that patient safety is protected and that decision makers understand the dangers an expanded scope of practice for pharmacists could mean for the Queensland health system.

We will keep members abreast of any updates on this issue.

AMA Queensland meets with the Colleges
In our ongoing efforts to support, promote and advocate for the medical profession in Queensland, AMA Queensland recently convened a roundtable of the combined Colleges, including the Royal Colleges of General Practitioners, Physicians, Surgeons, Ophthalmologists, Psychiatrists, the College of Emergency Medicine and the College of Rural and Remote Medicine.

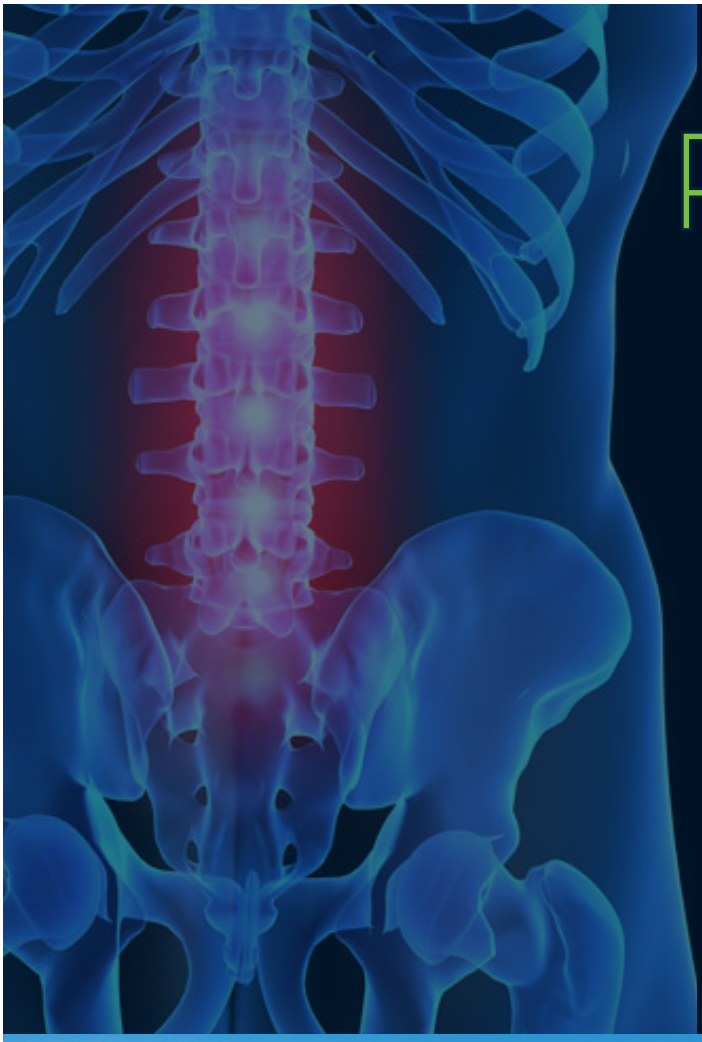
It was very positive and productive roundtable. The group discussed a number of issues, including Queensland Health's continuing efforts to expand scope of practice for non-medical health professionals and the proposed pharmacy council.

We also discussed the new laws surrounding mandatory reporting and all agreed that
- The wording of the bill was ambiguous and as a result doctors would avoid seeking treatment;
- Doctors deserved the same level of access to care for their own health as they provide for their patients;
- Practitioners were also patients and should have equal right to access confidential high quality medical treatment as their own patients and all other Australians; and
- Improved practitioner health led to improved patient protection.

AMA Queensland and the Colleges agreed to progress a joint statement on the new mandatory reporting legislation, expressing disappointment at the lack of genuine, positive reform these laws represent and urging the State Government to make improvements to the Bill.

Eradicating Hepatitis C
The dream of eradicating Hepatitis C from Australia is almost a reality thanks to two of our GP members. Drs Matt Young and Joss O'Loan volunteer their time and resources to take hepatitis C treatment directly to disenfranchised and chronically marginalised people. In October, the AMAQ Foundation raised $7,000 at the Dinner for the Profession for their Hep C Kombi Clinic project, enabling treatment for 100 new hepatitis C patients. You can support their efforts by donating at www.amaqfoundation.com.au/donation or calling (07) 3872 2222.

2019 Membership Renewal
We wish to remind all members that your 2019 membership is due for renewal. In November, you would have received your 2019 renewal notice. Take advantage of our monthly direct debit payment and don't forget about our member get member campaign offering a 25% discount for each new member you introduce. You can renew online at **www.ama.com.au/renew.** Membership is an investment in your future - Whether you're just starting out in your medical career or have an established practice, AMA Queensland is committed to protecting and enhancing your professional interest. **If you have any issues you feel need AMA Queensland's attention, please send us your thoughts directly via membership@amaq.com.au.**



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AMA QUEENSLAND

EDINBURGH

SCOTLAND

AMA QUEENSLAND ANNUAL CONFERENCE

SUN 22 - SAT 28 SEPTEMBER 2019

Doctors, practice managers, registered nurses and other medical industry professionals from around Australia are invited to attend the ***Annual AMA Queensland Conference*** in **Edinburgh, Scotland from 22-28 September 2019.**

The program will feature high-profile British, Scottish and Australian speakers on a range of medical leadership and clinical topics in an exciting, and unique location. RACGP points will be on offer.

To find out more about the conference program or to register, please contact:

Neil Mackintosh,
Conference Organiser
P: (07) 3872 2222 or
E: n.mackintosh@amaq.com.au

Download a conference brochure from the events calendar at www.amaq.com.au

New advanced cancer treatment at Icon North Lakes

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New Radiation Oncologists joining the team

Dr Jim Jackson

Sub-specialities: stereotactic radiation therapy, brain, head and neck, genitourinary, lung, skin and breast

Dr Mark Pinkham

Sub-specialities: stereotactic radiation therapy, brain, skin, melanoma, lung and lymphoma

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Stereotactic radiation therapy improves quality of life for cancer patients at Icon Cancer Centre North Lakes

Icon Cancer Centre North Lakes now offers stereotactic radiation therapy, including intra-cranial stereotactic radiation therapy (SRT), as well as extra-cranial stereotactic ablative body radiotherapy (SABR) for bony and lung lesions.

These treatment techniques are effective, clinically proven and non-invasive alternatives to traditional surgical options. The treatment is extremely precise and delivers conformal, high doses of radiation to the target tumour, with low doses deposited in nearby healthy tissues.

SABR is intended to improve a patient's quality of life with often curable intent for early stage lung cancers. The ultra-low doses of radiation deposited in normal, healthy tissues lead to minimal side effects, compared with other cancer therapies.

Icon Radiation Oncologists Dr Jim Jackson and Dr Mark Pinkham have extensive experience providing stereotactic radiation therapy and stereotactic ablative body radiotherapy, and are now offering this highly specialised treatment at North Lakes.

Dr Jackson says, 'By using precise three dimensional imaging and advanced treatment delivery techniques, stereotactic radiation therapy allows for larger amounts of radiation to enter the body across a shorter period of time,' he said.

Dr Jackson and Dr Pinkham are treating both intra-cranial SRT and extra-cranial (lung and bone) SABR at Icon Cancer Centre North Lakes utilising state-of-the-art treatment technology including a Varian TrueBeam linear accelerator with advanced patient positioning monitoring, including respiratory monitoring.

These advanced treatment techniques complement Icon's existing radiation therapy service that includes the latest in treatment technology and approaches for all cancer types.

What conditions are suitable for stereotactic SRT or SABR?

- brain metastases, following or instead of surgery
- benign and malignant brain tumours
- primary lung cancers
- lung metastases
- bony metastases

GPs and specialists can refer patients directly to Icon Cancer Centre North Lakes

Reflections of a QDHP phone counsellor

Dr Michael Kennedy reflects on his experience as a phone counsellor for the Queensland Doctor's Health Programme, and encourages others to consider joining the team.

Years ago, an opportunity arose, akin to a tap on the shoulder to do this job of taking the calls for DHAS(Q), now the Queensland Doctor's Health Programme. It was largely a spontaneous decision in just getting on with it.

So, it doesn't have to be a really big earth shattering decision to do this, although things are a little different to 20 years plus ago, I was a GP about 10 years out in general practice. GPs are well suited to this job. To be able to listen to the person on the other end of the line and get as much information as you can, not only the story, but the accent, anxiety level etc etc.

You need to be able to write quickly. I imagine the modern doctors are able to write still, as my writing deteriorated much before the key board. You are involved more often with problems arising in the more bureaucratic world in which we now live e.g. students and registrar level in my experience.

Anyway, why would one want to do it?

Well, it is interesting actually and over time you get to know more about doctors' health. Another string to your bow, so as to speak. You will be involved with another group of doctors involved in this. I remember looking at the list of names and seeing people's names who I respected and knew were capable doctors. So in that sense it's nice to be part of something like this.

YOU may get a fuzzy feeling because you are helping your colleagues.

Or a sense of satisfaction because you're doing your bit in the bigger medical community without the fanfare. Does that sound boring? Not really!

You know to always ask a busy person if you want something done.

I believe that you need to feel supported and I think that this has improved since the early days. So, it is important not to feel that one has to solve things straight away, rather to communicate to see what can be done, and this is where the support is needed and possible follow up.

Well I hope that maybe one reading this may start to consider this as a thread in their medical coat or dress.

Any rate, enjoy this part of your medical life and know that some doctors have been helped and careers changed by your discipline and learning.

All the best, whatever you may decide.

If you are interested please send an email to president@dhasq.org.au. For further information about DHAS(Q), please refer to our website: http://dhasq.org.au/. Our GP phone counsellors are on call for 1 week about every 30 weeks, it averages out to 3 times per biennium. The call is 24 hours per day for a 7 day period Monday to Monday. During office hours the calls are taken by a counsellor from QDHP and then if needed the on call GP is contacted. After hours the on call GP is the first responder. The calls average 6 per week, sometimes less and sometimes more. The GP on call is well supported by experienced members of the DHASQ committee and a panel of psychiatrists.

Update on Adult Sleep Study Item Numbers

Dr James Douglas
Sleep & Thoracic Physician
NBST

Dr Andreas Fiene
Sleep & Thoracic Physician
NBST

The MBS review of sleep study item numbers has recently concluded. The major changes are:

- to identify which patients with a high pre-test probability of symptomatic moderate to severe OSA (Severe OSA) can be directly referred for sleep studies without necessarily being reviewed by Sleep Physician prior to the study &
- the default position for patients with the above high pre-test probability of severe OSA with minimal co-morbidities will be a home diagnostic sleep study (important co-morbidities that indicate a patient should proceed to an in-lab study are listed below) &
- patients without a high pre-test probability for severe OSA, must see a Sleep or Thoracic Physician prior to being considered for a Medicare billed sleep study &
- for all Medicare billed treatment studies e.g. CPAP study, Bilevel study, assessment of oral appliance, positional therapy, etc. the patient must see a Sleep or Thoracic Physician prior to the study.

Referrers will need to provide more information to allow the Sleep Physician to promptly process the referral and ensure the patient undertakes the most appropriate sleep study. North Brisbane Sleep & Thoracic has updated its referral form.

This is accessible though our website www.nbst.com.au on the tab “Refer to us,” “For Doctors” and the form entitled “Medicare Compliant referral.”

If would like to receive a hard copy of our new referral pads, please call 1300 391 820 or email practicemanager@nbst.com.au and we will post out referral pads to your practice.

Diagnostic sleep studies

Patients with a high pre-test probability for severe OSA may proceed directly to a sleep study.

The high pre-test probability is based on (a positive screening questionnaire e.g. OSA50 score ≥ 5 or STOP-BANG score ≥ 4 or the Berlin Questionnaire yielding a high-risk result) and an Epworth Sleepiness Scale score ≥ 8.

The easiest screening questionnaire to administer is the OSA-50 which was developed in Australia for General Practitioner settings.

This is listed below:

	Score
Obesity -Waist measurement at umbilicus male ≥ 102 cm, female ≥ 88 cm	**3**
Snore – Has the patient’s snoring ever bothered other people?	**3**
Apnoea – Has anyone reported apnoeas during the patient’s sleep	**2**
50 – Is the patient older than 50 years of age?	**2**
Total score out of 10.	

Patients who do not meet the above high pre-test probability for severe OSA, who wish to have a Medicare rebated sleep study, must undertake a Sleep or Thoracic Physician review prior to the sleep study.

Once the pre-test probability for severe OSA has been determined, the next question is the patient’s suitability for a for a home study or an in-lab diagnostic sleep study.

Important conditions where an in-lab study is recommended are listed below. Any of the following warrant the patient proceeding to an in lab diagnostic study:

- the presence of any significant underlying cardiac disease e.g. significant cardiac arrhythmias, heart failure,
- advanced respiratory disease,
- neurological diseases, especially neuromuscular disease,
- conditions that increase the risk of central sleep apnoea syndrome, - heart failure, regular opioid use, significant chronic kidney disease,
- sleep hypoventilation syndrome likely,
- where a co-existing parasomnia or seizure disorder is suspected,
- where accurate body position during sleep is regarded as essential and would not be recorded as part of a home study,
- acromegaly or hypothyroidism,
- previous failed or inconclusive home study,
- suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment;
- patient preference is not for a home study or home study is not feasible,
- unexplained sleepiness (not due to environmental or sleep hygiene issues)

Treatment studies:

The other major change is that all in-lab studies to assess treatment efficacy e.g. CPAP study,

effect of oral appliances on OSA, positional therapy, etc. now require a Sleep physician review prior to an in-lab treatment study.

For many patients who have been diagnosed with uncomplicated obstructive sleep apnoea with none of the above co-morbidities, it is reasonable for these patients to proceed to an auto-titrating positive airway pressure (APAP) trial with oversight by a doctor.

We are happy to provide this oversight, but must review the patient during the trial.

Conclusions:

Dr Fiene and myself would be happy to answer any questions related to these new changes.

We are contactable during office hours on telephone 1300 391 820. We will continue to provide the high level of service that your patients have currently enjoyed.

We appreciate that there may be many questions related to the transition to the new MBS rules.

NBST will continue to provide bulk billed sleep studies for patients that fulfil the Medicare criteria.

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AMA

CLOSING THE GAP STRATEGY UNRAVELLING – TIME TO REBUILD, NOT REFRESH

AMA Indigenous Health Report Card 2018 – Rebuilding the Closing the Gap Health Strategy

The Closing the Gap Strategy is unravelling, and must be rebuilt from the ground up to have any chance of closing the life expectancy gap between Indigenous and non-Indigenous Australians, AMA President, Dr Tony Bartone, said today.

Dr Bartone today launched the AMA Indigenous Health Report Card 2018, the AMA's annual analysis of an area of Aboriginal and Torres Strait Islander health across the nation.

This year's Report Card scrutinises the 10-year-old Closing the Gap Strategy, and recent efforts to "refresh" the Strategy.

"It's been a decade since the Council of Australian Governments (COAG) launched the Closing the Gap Strategy, with a target of achieving life expectancy equality by 2031," Dr Bartone said.

"But 10 years on, progress is limited, mixed, and disappointing. If anything, the gap is widening as Aboriginal and Torres Strait Islander health gains are outpaced by improvement in non-Indigenous health outcomes.

"The Strategy has all but unravelled, and efforts underway now to refresh the Strategy run the risk of simply perpetuating the current implementation failures.

"The Strategy needs to be rebuilt from the ground up, not simply refreshed without adequate funding and commitment from all governments to a national approach."

The Report Card outlines six targets to rebuild the Strategy:

- committing to equitable, needs-based expenditure;
- systematically costing, funding, and implementing the Closing the Gap health and mental health plans;
- identifying and filling primary health care service gaps;
- addressing environmental health and housing;
- addressing the social determinants of health inequality; and
- placing Aboriginal health in Aboriginal hands.

"It is time to address the myth that it is some form of special treatment to provide additional health funding to address additional health needs in the Aboriginal and Torres Strait Islander population," Dr Bartone said.

"Government spend proportionally more on the health of older Australians when compared to young Australians, simply because elderly people's health needs are proportionally greater.

"The same principle should be applied when assessing what equitable Indigenous health spending is, relative to non-Indigenous health expenditure.

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"The Australian Institute of Health and Welfare estimates that the Aboriginal and Torres Strait Islander burden of disease is 2.3 times greater than the non-Indigenous burden, meaning that the Indigenous population has 2.3 times the health needs of the non-Indigenous population.

"This means that for every $1 spent on health care for a non-Indigenous person, $2.30 should be spent on care for an Indigenous person.

"But this is not the case. For every $1 spent by the Commonwealth on primary health care, including Medicare, for a non-Indigenous person, only 90 cents is spent on an Indigenous person – a 61 per cent shortfall.

"For the Pharmaceutical Benefits Scheme, the gap is even greater – 63 cents for every dollar, or a 73 per cent shortfall from the equitable spend.

"Spending less per capita on those with worse health, and particularly on their primary health care services, is dysfunctional national policy. It leads to us spending six times more on hospital care for Indigenous Australians than we do on prevention-oriented care from GPs and other doctors.

"We will not close the gap until we provide equitable levels of health funding. We need our political leaders and commentators to tackle the irresponsible equating of equitable expenditure with 'special treatment' that has hindered efforts to secure the level of funding needed to close the health and life expectancy gap."

The AMA 2018 Indigenous Health Report Card is at https://ama.com.au/article/2018-ama-report-card-indigenous-health-rebuilding-closing-gap-health-strategy-and-review

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22 November 2018

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Redcliffe Hospital GP Liaison Update – November 2018

Dr James Collins mngplo@health.qld.gov.au

GP Advice Lines now available from Metro North Hospitals

Metro North GPLO program works closely with speciality groups across the public hospitals in Metro North. We have heard the need at our GP education events for the need to provide advice lines for GPs and so have created a list of advice lines now available across Metro North's public hospitals.

A copy of the advice line poster is available for GPs from the Metro North GPLO team by emailing- mngplo@health.qld.gov.au

GP Education for 2019

The GPLO team have run a range of successful GP education events in Metro North public hospitals and we would like to inform you there will be a range of monthly education sessions next year. Topics will include genetics, oncology, persistent pain, paediatrics & much more, .
To keep informed of upcoming events and to sign up to our monthly one-page GP Bulletin, please email mngplo@health.qld.gov.au

Health Pathways update

Health Pathways is a centralised GP hub developed specifically for Brisbane North GPs to access the latest health sector news and local guidance for the assessment and management for a range of medical conditions.
There are now over 350 HealthPathways online.
They also provide useful resources for you and your patient include details of services available in the district.

For access go to:
www.brisbanenorth.healthpathwayscommunity.org

If you are a GP and don't currently have access, phone the Pathways Program team on 07 3630 7300 or email healthpathways@brisbanenorthphn.org.au. They can also arrange a demonstration.

Health Pathways complements Metro North's GP referral guidelines site
www.health.qld.gov.au/metronorth/refer

Wounds in My Pocket Guide & Chronic Wound supports

There are a range of new resources available to GPs to help deal with chronic wounds. Health Pathways have management guides to assist GPs with chronic wounds and a recently updated service directory for Brisbane North is available - https://metronorth.health.qld.gov.au/specialist_service/refer-your-patient/chronic-wounds-directory

Dr Dianne Smith, Chronic Wounds specialist at Royal Brisbane Hospital has created a quick guide to chronic wounds that is available as a PDF. If you would like to get a copy of this useful chronic wound guide, contact us on mngplo@health.qld.gov.au

Health Provider Portal Update - real-time access to hospital results

Over 500 GPs in Metro North have signed up to the Health Provider Portal (Viewer). Queensland GPs now have real time access to results including pathology, radiology, medications, appointments and much more at their fingertips.

If you haven't signed up yet, here are a few tips to make the process easier.

Because the system operates with strict identification requirements, it's a good idea to have your practice manager check to ensure the details for your practice are up to date. The registration process for you and your practice with support documents/videos can be found at http://bit.ly/hppinfo
If you need further assistance contact mngplo@health.qld.gov.au to arrange a practice visit or contact your Brisbane North PHN's primary care liaison officer.

If you would like to provide any feedback or suggestions to the GP Liaison Team at Metro North, please email us as we are always keen to have feedback.

FIVE Estate Planning tactics to preserve Family Wealth

Over the years we have witnessed first-hand what can happen when a client's Estate Plan hasn't been structured correctly.

We think it's important to preserve the Family Wealth and pass assets onto future generations, below are 5 key points to think about and act on.

1. **Start with a Structure review**
   Assets can be held in different names/entities based on your past purchases, inheritances or marital splits. A review of what legal entity is the owner of assets should be undertaken as there are ways to "structure" the ownership of assets to assist and minimise the passing of family assets to the next generation. Effective structuring can save on financial or taxation consequences.

2. **Super is not part of your Estate**
   Why does super need to be reviewed? Super does not automatically form part of a person's estate. Whilst we see most clients do have a Will in place, often their superannuation has not been considered.

   TIP: A member can elect to include their death benefit in their estate by completing a binding or non-lapsing death nomination in favour of either their financial dependants or their legal personal representative. This is a very important election as a correct election can save tax where a financial dependant exists.

3. **Plan your Business Exit**
   If you run and own your own business, you'll need to think how someday you will exit that business. The processes you put in place surrounding your exit can have a huge impact on your retirement plans both in time and money.

   TIP: Business owners need to prepare a plan for their exit, their successors, how the successors will fund future ownership and how you address legal & tax issues. This should ensure your assets are protected and you are compensated for all of your hard work in retirement.

4. **Consider Aged Care fees**
   Be aware of Aged Care fees and possibly create a strategy to fund future care to ensure family assets are structured to pay for your own Aged Care costs. Potential Centrelink issues should also be considered when creating this strategy.

   TIP: Ensure a percentage of investments have the liquidity to be readily available to fund accommodation payments, basic daily care fees and other fees for additional services.

5. **Seek ongoing support**
   We often come across clients who created an Estate Plan and then have never updated or sought advice as their circumstances change. Not only do family assets change but so do family members via marriage, divorce, births & deaths etc.

   TIP: Regularly update your Accountant and Investment advisor with family updates regardless of how big or small to help protect your family assets and to have peace of mind.

   If you have any questions feel free to call me 07 54379900. *Article Written by Kirk Jarrott*

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AMA URGES CAUTION ON NEW DEFENCE HEALTH SERVICES CONTRACT

AMA President, Dr Tony Bartone, is urging the Government to be cautious and vigilant in the operation of defence force health services under the new successful tenderer, which is yet to be made public.

Dr Bartone said that the existing contractor, Medibank Health Solutions (MHS), has been informed by the Australian Defence Force (ADF) that it has been unsuccessful in its bid to continue to provide defence health services under the Garrison Health Services contract.

“The successful tenderer has been advised, but not publicly announced,” Dr Bartone said.

“The AMA will be calling on the Government and the successful tenderer to work closely with the medical profession to ensure that ADF personnel receive the best possible care under the new arrangements.

“Our defence personnel deserve quality health care, but we have witnessed problems in the past.

“The AMA was highly critical of the Medibank Health Solutions (MHS) approach to the provision of medical services when it was first awarded the Garrison Health Services Contract in 2012.

“Many GPs and other medical specialists refused to provide care under the arrangements implemented by MHS.

“There was widespread concern about MHS decisions, including significant fee cuts, unfair contracts, its control of referral arrangements, and poor consultation with the profession particularly in the initial period after the contract was awarded.

“The AMA has welcomed efforts by the Australian Defence Force to accept AMA input and advice in the development of its tender documents, but the onus is now on the selected provider to avoid making the same mistakes that disadvantage defence personnel and doctors.

“Our serving personnel deserve the best possible care from the right medical professionals, but we must avoid a managed care-style system at all costs.

“The successful tenderer will need to work closely with the profession in the development of suitable contracts for the medical professionals who look after ADF personnel.

They will need to implement referral arrangements that are based on choice and quality, not the lowest cost.

“The AMA looks forward to working with the new contractor to ensure our ADF personnel receive the high-quality health services they richly deserve,” Dr Bartone said.

21 November 2018

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Notice to New and Past Members

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Dear Doctors

The Redcliffe and District Medical Association Inc. have had another successful year of interesting and educative meetings on a wide variety of medical topics. Show your support for your Local Medical Association to continue the only local convocation for general practitioners and specialists to socialise and to discuss local and national medico-political issues.

This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and speakers are most welcome. Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost.

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Treasurer Dr Peter Stephenson Email; GJS2@internode.on.net

ABN 88 637 858 491

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

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

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

Where We Work and Live

"Rembering Ernest Albert Corey"

From Wikipedia, the free encyclopedia https://en.wikipedia.org/wiki/Ernest_Corey

In honour of Corporal Ernest Albert Corey. The only soldier ever to have been awarded a military medal and 3 bars 1891–1972. Ernest Albert Corey, MM & Three Bars (20 December 1891 – 25 August 1972) was a distinguished

Australian soldier who served as a stretcher bearer during the First World War. He enlisted in the Australian Imperial Force on 13 January 1916, and was allocated to the 55th Battalion, where he was initially posted to a grenade section before volunteering for stretcher bearing duties.

In 1917 he was twice awarded the Military Medal for his devotion to duty in aiding wounded soldiers, and twice again in 1918; becoming the only person to be awarded the Military Medal four times.

Born in New South Wales, Corey was employed as a blacksmith's striker upon leaving school. In January 1916, he became a member of the "Men from Snowy River" recruiting march, enlisting in Goulburn. Returning to Australia after the Armistice, he was discharged on medical grounds in 1919 and was employed in a number of jobs before re-enlisting in a militia battalion for service in the Second World War. He died in 1972 and was buried with full military honours in the Ex-Servicemen's section of Woden Cemetery, Australian Capital Territory.

Early life

Corey was born on 20 December 1891 in Numeralla, New South Wales, the eighth child of Thomas Corey and his wife Ellen, née Burke. He was educated at Thubergal Lake Public School,[1] before leaving to become a blacksmith's striker at Martin's Smithy in Cooma. In January 1916, Corey marched from Cooma to Goulburn as a member of the "Men from Snowy River" recruiting march, and enlisted on 13 January. Along with the majority of other members of the march, he was allotted to the 55th

'Men from Snowy River' at Cooma.

Battalion.

First World War

Following training at Goulburn camp, he embarked for overseas on 4 September aboard HMAT Port Sydney with the 4th Reinforcements for the 55th Battalion.[4] Arriving in England, he spent three months with the 14th Training Battalion at Hurdcott Camp near Fovant in Wiltshire, before joining the 55th Battalion on 8 February 1917 at Montauban, France. Posted to the grenade section of "C" Company, he took part in the capture of Doignies in April.

On 15 May, Corey's brigade was in action near Quéant. Suffering heavy losses, the Commanding Officer of the 55th called for volunteers to assist the stretcher bearers; Corey was one of thirty men who volunteered. For seventeen hours, he assisted in carrying the wounded approximately 2 kilometres (1.2 mi) back to the dressing station; he was awarded the Military Medal for this action.

Following engagements at Bullecourt, the 5th Division—of which the 55th Battalion was part—spent four months in reserve, before moving into the Ypres sector in Belgium.[3] Made a regular stretcher bearer, Corey was decorated with a bar to his Military Medal for his actions on 26 September during the Battle of Polygon Wood. While subject to heavy artillery and machine gun fire, he frequently ventured out into no-man's-land to tend to the wounded.

During the winter of 1917–1918, the 55th Battalion was posted to the Messines sector, where Corey was granted leave to the United Kingdom in February 1918.

Continued next month