REDCLIFFE & DISTRICT and BRISBANE LOCAL MEDICAL ASSOCIATION

RDMA & BLMA's Joint Newsletter

Newsletter November 2019

HTTPS://WWW.FACEBOOK.COM/REDCLIFFEANDDISTRICTMEDICALASSOCIATION/

"The Uncle We Never Knew" https://www.awm.gov.au/articles/blog/re-membering-Ivor-Whittaker by Clare Hunter

See Where We Work & Live P20. Ivor Whittaker

RDMA President's Report Dr Kimberley Bondeson

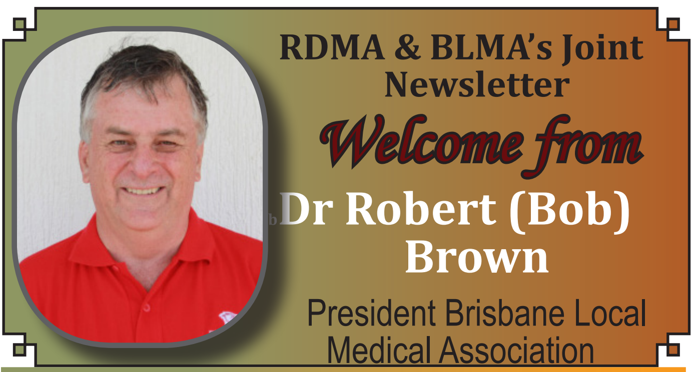
We are in the middle of a terrible fire season, with wildfires running rampart over New South Wales and parts of Queensland. High temperature and winds are making the fires worse, with reports that fire ambers are been spread 30km's ahead of fires by high winds. This associated with increased population density and a preference to live near our forests and trees, along with heavy undergrowth, are making perfect fire conditions.

Both Queensland and New South Wales have been declared a State of Emergency. 150 homes have been lost to date in New South Wales, along with 3 lives. Even on the Redcliffe Peninsular, there is a smoke haze that has been around for days, and windy conditions outside. The news is telling us that the air quality in Sydney is worse than that of Beijing, and Brisbane air quality is not much better. The Queensland Chief Health Officer is advising everyone to stay indoors and not go out un-necessarily. In New South Wales, there are many schools closed due to the fires. I can't say I can remember anything in the past where the warnings and advice have been so dramatic, and it is certainly working to keep people informed. I am surprised that I have not seen more asthma in my clinic, but have been taking advantage of the situation to advise my patients about their asthma management.

On another topic, the Ambo's (Victorian Ambulance Union) are pushing for ''back of house'' pill testing at music festivals – in NSW this is not approved by the current government, despite a recent Coroner's report which has recommended that pill testing at festivals be introduced, along with decreasing police presence and sniffer dogs. This topic and recommendation from the Coroner follows a string of deaths related to dangerous batches of pills (which are illegal) causing death in young music festival participants. The report describes that one particular Coroner went as part of her research into the death of a young woman at a festival, and actually attended several festivals to see what was going on. There are stories of que's of young people lining up to enter a festival, and police presence doing searches for drugs, and sniffer dogs looking for drugs. There are reports that young people who are standing in line stuffing all their illegal drugs into their mouths, and taking them all at once, in order to prevent them been found by the police or the sniffer dogs.

The ACT government is currently allowing its second pill testing trial at this year's "Groovin the Moo" festival. It is with interest that we await the outcome of these trials.

The Festive season is nearly upon us. Seasons Greeting to all.
Kimberley Bondeson



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

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

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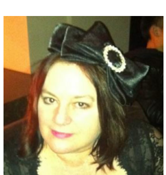

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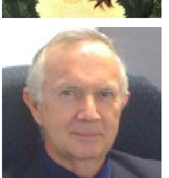

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UPDATED

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 New Date		
✓ Friday	November	22nd

NEWSLETTER DEADLINE

Advertising & Contribution 15th December 19

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	10th
✓ 6	November	29th

Next Meeting Date 22nd November 2019

RDMA Meeting 29.10.2019

Dr Kimberley Bondeson RDMA President Introduced Sponsor Representative: Kelly Grant and Robyn Carrington

Speaker
Dr Amanda O'Rielly, Orthopaedic Surgeon
Topic : "When do Patients really need to see the Orthopaedic Surgeon"
Sponsor: Peninusula Private Hospital

Photos (Left to Right & Down):
1. Speaker Dr Amanda Reilly
2. Kelly Grant and Robyn Carrington sponsor reps
3. Kelly, Amanda and Robyn
4. New Member Jane Davidson & Colin Chow.

End of Year Networking Party

Redcliffe & District Medical Association Inc.

DATE: **Friday 22nd November 2019**

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.
Guest Speaker: Dr Geoffrey Hawson
Topic: "An Update on Australian Senior Active Doctors Association (ASADA)"
8:00pm - Main Meal
8:30pm - General Business, Dessert, Tea & Coffee

RSVP: By Wednesday 20th November 2019
(e) RDMA@qml.com.au or 0466 480 315

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- Payments required within 10 working days or discounts will be removed unless a payment plan is outlined at the outset.

CLASSIFIEDS

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.

Australian Senior Active Doctors Association
Dr Geoffrey Hawson, ASADA PRESIDENT

ASADA Membership Information

The ASADA Management Committee encourages you to read through this information and consider joining the new ASADA by filling in the members form (emailed to the membship and at RDMA's Meeting on 22/11/19), and sending your cheque in.

The mailing address is PO Box 223, Redcliffe Q 4020. (Geoff Hawson Secretary RDMA, and President of ASADA)

The RDMA executive has been active in promoting the plight of senior and semi-retired doctors, including conducting a survey of members on issues concerning senior doctor contributions to the profession and step-down registration (see previous RDMA newsletters).

As a result of this, the inaugural meeting of the re-formed Australian Senior Active Doctors Association was held in Scarborough on the 10th November. RDMA members may be aware of the association (ASADA Inc) which was founded by Dr Frank Johnson in 2011 with support from the Australian Doctors Federation.

After Dr Johnson's untimely death in 2013 and the loss of his strong leadership, the association became less active and was ultimately deregistered.

Geoff Hawson has taken on the role of President of ASADA. At the meeting, Kimberley Bondeson was appointed Secretary and Peter Stephenson, Treasurer.

Geoff Hawson, as the Retired Doctors Representative on AMAQ, has advocated at AMA National Conferences and at AMAQ meetings, while Kimberley Bondeson gave a soapbox presentation at the 2019 AMAQ conference in Edinburgh, alerting AMA members to the issues.

There has been strong interest and support from RDMA members for changes to the current regulations which prevent senior doctors contributing their expertise through a graded transition to full retirement.

While RDMA has championed the concerns of senior doctors, ASADA, as a dedicated national association can lobby more effectively and better represent senior doctors across Australia.

Membership is not limited to senior doctors as all doctors will one day face these issues. We would therefore encourage all RDMA members to join ASADA.

A brief meeting of ASADA will be held at the conclusion of the RDMA Meeting on 22nd November. At this meeting members will vote on incorporation of ASADA in Queensland.

The association's aims are:

1. To maintain, advance and promote the ethical standards, integrity and reputation of Australian Senior Active Doctors.

2. To maintain, advance and promote the active contribution of Senior Active Doctors to Australian medicine and Australian healthcare and the maintenance of clinical privileges within a framework of evidence based public regulation of Australian medical practice.

3. To develop and promote policies that maximise the contribution of Australian Senior Active Doctors to Australian healthcare and allow for graded transition of roles for senior years of practice at the discretion of the senior doctor.

4. To research, develop, establish and promote policies that will mobilise the contribution of Australian Senior Active Doctors to Australian healthcare.

5. To advise and encourage learned medical colleges to conduct continuing professional development programs which meet the needs of Australian Senior Active Doctors.

6. To represent industrially and politically the professional concerns of Australian Senior Active Doctors.

7. To build and strengthen the relationship between Australian Senior Active Doctors and other members of the Australian medical profession and to promote fellowship between Australian Senior Active Doctors.

8. To encourage the involvement of Australian Senior Active Doctors in issues of concern to the medical profession, including active involvement and participation in medical organisations and learned medical colleges which recognise the contribution and potential contribution of Australian Senior Active Doctors.

Dr Geoffrey Hawson, ASADA President

AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

Issuing Cause of Death Certificates for Apparent Natural Causes Deaths

A Guide for Queensland Medical Practitioners

I give a talk on the most cost-effective interventions to increase life expectancy.

It starts by quoting cause of death figures from the Bureau of Statistics. I have taken to adding a commentary that the causes of death figures are changing.

What is different is that we see fewer strokes and heart attacks and pneumonias.

Why? Because the Coroners started saying that they would accept “dementia” as a cause of death.

We who work in aged care say that death certificates are among the world’s greatest works of fiction.

We needed a reasonable hypothesis, and ideally one that would not distress relatives and descendants.

Now we can write “dementia”. And the Australian statistics changed to reflect the Coroners’ policy.

The Queensland Coroner has issued new guidelines that make it easier, and legally less hazardous, for doctors to write death certificates.

The reason given is to prevent the Coroner’s limited resources from being tied up investigating deaths that are from natural causes, didn’t arise in suspicious circumstances, and won’t lead to police investigations and prosecutions.

Doubtless, the police are happy about this too - anything to save the paperwork and wasted time.

Doctors must be happy to know that their job is easier and less hazardous, although the guidelines make it clear that doctors can issue death certificates for patients they have never seen.

Without wanting to appear venal - is anybody going to pay for this?

Form 9 is clearly endorsed with the proviso that no fee can be charged for completing the form.

So private practitioners are not going to head down this path, are we?

See page 7 and page 8 for Issuing Cause of Death Certificates for Apparent Natural Causes Deaths and A Guide for Queensland Medical Practitioners by the Coroners Court of Queensland.

Branch Councillor
Dr Wayne Herdy

ISSUING CAUSE OF DEATH CERTIFICATES FOR APPARENT NATURAL CAUSES DEATHS

- A guide for Queensland medical practitioners

From time to time you may be approached by police or a family member to issue a cause of death certificate (Form 9) for a patient who appears to have died from natural causes.

This fact sheet addresses common concerns about health professionals' ability to issue a death certificate in these circumstances. It also explains when a death certificate should not be issued because the death is reportable to the coroner.

What am I entitled to know about how the person died?

You can and should ask police for information about the circumstances in which the person died or their body was found.

Can I review the patient records first?

You can and should ask police for a reasonable period of time to review the person's records.

It may also be helpful for you to speak to other medical practitioners involved in the person's care. Some examples include other general practitioners, specialists or treating hospital doctors. You may also ask to see records made by them.

You have **two working days** within which to decide whether you can issue a death certificate.

Timely issuing of death certificates significantly reduces family distress and unnecessary disruption to funeral arrangements.

I haven't seen the person recently?

There is **no longer** any requirement for you to have seen the person within a certain timeframe (e.g. three months) to be able to issue a death certificate.

I haven't examined the person's body?

There is **no** requirement for you to have viewed or examined the person's body before you issue a death certificate.

I'm certain it was a natural causes death, but I don't know the exact cause of death.

In order to complete the death certificate you are required by law to form an opinion as to the **probable** cause of death, taking into account what you know about the person's medical history and the circumstances of their death.

It may help to discuss your thinking about the probable cause of death with a colleague.

You can also discuss the death with a Forensic Medicine Officer (FMO) from the Department of Health, Clinical Forensic Medicine Unit. FMOs are doctors who assist the coroner by providing clinical advice about reportable deaths. They can help you by acting as a clinical '*sounding board*' for your thinking about probable cause of death and how to write up the death certificate.

Contact:

(07) 3405 5755 (business hours – ask for the FMO on coronial duties);

The person wasn't my patient?

There is **no** requirement for you to have treated the person.

You can issue the death certificate provided you have had an opportunity to consider information about the person's medical history, for example, by reviewing patient records or speaking to another doctor involved in the person's care and you can form an opinion as to the probable cause of death.

I want to know if the family is happy for me to issue a certificate.

If you feel comfortable issuing a death certificate, you can and should contact the person's family to explain what you consider the probable cause of death to be and why.

Families are generally very appreciative of this contact and it gives you an opportunity to be alerted to any issues of concern that might better be referred to the coroner.

Coroners Court of Queensland

I want to know the coroner is happy for me to issue a certificate.

An apparent natural causes death is reportable to the coroner **only** if a probable cause of death is genuinely not known.

The Coronial Registrar, Coroners Court of Queensland is available during business hours to discuss the death with you and advise whether it is appropriate for you to issue a death certificate.

Contact: Coronial Registrar
(07) 3738 7050 (business hours)

Contact: On-call coroner
(07) 3247 3372 (after hours)

What if the person recently had surgery?

Just because the person had surgery within four weeks of the death does not make the death reportable to the coroner. The death is reportable **only** if you consider the surgery has caused or contributed significantly to, or hastened the person's death ('health care related death').

Contact the Coronial Registrar for advice if you think the death could be health care related.

What if the person recently had a fall?

If you consider a fall-related injury (e.g. fractured neck or femur or subdural haematoma) has caused or contributed significantly to, or hastened the death, the death must be reported to the coroner.

Contact the Coronial Registrar for advice about whether the death needs to be reported and if so, how to report it.

When shouldn't I issue a death certificate?

You should **not** issue a death certificate if you have any concern the person may have taken their own life, has died a violent or otherwise unnatural or suspicious death (e.g. accidental drug overdose, choking, traumatic injury) or you are aware the family has concerns about the health care provided to the person before they died.

In these circumstances, you should explain your concerns to police, who will refer the death to the coroner.

Any death of a patient with a disability who lived in supported residential accommodation, had a mental illness who was receiving involuntary treatment at the time of their death or was a child in care or under guardianship of the State, is also reportable to the coroner.

You can contact the Coronial Registrar for advice about how to report these deaths.

For guidance completing a cause of death certificate

More information about how to complete a cause of death is available for GPs and other clinicians on *HealthPathways*. To find out if *HealthPathways* is active in your health area, contact your local Primary Health Network (PHN). For details visit - http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Locator.

Further information:

Coroners Court of Queensland
– https://www.courts.qld.gov.au/courts/coroners-court

Information for health professionals https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/92868/m-osc-fs-information-for-health-professionals.pdf

The Royal Australian College of General Practitioners (RACGP) 'How to complete a death certificate – A guide for GP's' article - https://www.racgp.org.au/download/documents/AFP/2011/June/201106bird.pdf

Births, Deaths and Marriages Registration Act 2003 section 30 - 'cause of death certificate' – https://www.legislation.qld.gov.au/view/whole/html/inforce/current/act-2003-031

Contact details

This guide has been prepared by the Coroners Court of Queensland in partnership with the Queensland Police Service and the Department of Health, Clinical Forensic Medicine Unit.

If you have any enquiries or feedback about the guide, please email: state.coroner@justice.qld.gov.au.

Version 4 – September 2019

sports & spinal™

Happy Holidays!

The holiday season is a wonderful time for us to remember those who help our business and make our jobs a pleasure all year round. Sports & Spinal would not be possible without the local medical communities' continued support.

From the entire team at Sports & Spinal, may your New Year be filled with success, happiness & health!

New Medicare rebates for breast MRI and PET-CT now available at Qscan

From 1st November 2019, Qscan will bulk bill all Specialist referred MRI and PET-CT breast scans that meet the new Medicare criteria

Positron Emission Tomography

61524 – Whole body FDG PET study, performed for the staging of locally advanced (Stage III) breast cancer, for a patient who is considered suitable for active therapy.

61525 – Whole body FDG PET study, performed for the evaluation of suspected metastatic or suspected locally or regionally recurrent breast carcinoma, for a patient who is considered suitable for active therapy.

Locations

PET Breast is available at Qscan North Lakes
9 McLennan Court, North Lakes, QLD 4509
Ph: 07 3448 8840 Fax: 07 3880 6118

MRI Breast is available at Qscan Redcliffe
6 Silvyn Street, Redcliffe, QLD 4020
Ph: 07 3357 0922 Fax: 07 3283 4277

Magnetic Resonance Imaging

63533 – MRI scan of both breasts for the following
- The patient has been diagnosed with a breast cancer; and
- There is a discrepancy between the clinical assessment and the conventional assessment of the extent of the malignancy; and
- The results of the breast MRI imaging may alter treatment planning.

63531 – MRI scan of both breasts for the following
- The patient has a breast lesion; and
- The results of conventional imaging are inconclusive for the presence of breast cancer; and
- Biopsy has not been possible.

Book online today **qscan.com.au/bookings**

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

A new online platform for doctors to drive the agenda: Queensland Doctors' Community

AMA Queensland has just launched Queensland Doctors‘ Community (QDC), a new real-time, peer-to- peer online community forum for doctors in Queensland.

Queensland Doctors‘ Community is a member-only, private and secure community for you to connect with colleagues, share your challenges, uncertainties and successes, and importantly drive the healthcare agenda.

The key role of AMA Queensland is to support, promote and advocate for members, and your views from the coal face ensures we are fighting for what’s really important to you.

QDC has seen some interesting discussions in its first weeks. Members across the state have been logging on and discussing general practice billing, QIP Incentive issues, private health insurance, pharmacy prescribing trial, maternity services, climate change, ieMR issues, junior doctor fatigue and bullying, and entry criteria for training programs, to name a few.

QDC features a discussion forum as well as a library for sharing documents, resources, links and more.

I encourage you to login, join the conversation and see what your colleagues are saying.

The more you participate, the stronger our community will be.

You can find the platform at https://community.amaq.com.au - Log in with your AMA ID and password and post a message in the Open Forum discussion group

I look forward to seeing you on Queensland Doctors‘ Community.

Government rules out autonomous prescribing for pharmacists

In October, Federal Health Minister Greg Hunt ruled out changing guidelines to allow prescribing by pharmacists, backing the decision of the Pharmacy Board not to pursue autonomous prescribing.

In a Position Statement released in October, the Pharmacy Board of Australia outlined that autonomous prescribing by pharmacists would require additional regulation, changes to State and Territory legislation, and an application to the Ministerial Council, which could only proceed following the development of a registration standard. In its statement, the board said it was “not making an application for approval … at this time”.

The board’s statement was published 24 hours after the AMA released its *10 Minimum Standards for Prescribing,* which are available at www.ama.com.au.

The AMA Standards are consistent with medical ethics and frameworks for the quality use of medicines.

Continued Page 11

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Queensland Fires - Member assistance and support

With large parts of Queensland hit by bushfires, we are aware that many of our members may be directly affected.

Workplace advice and support - For any queries in relation to practice closures, general health and safety issues, staff unable to get to work, rostering and overtime, you can contact the AMA Queensland Workplace Relations Team on (07) 3872 2222.

Look after your own health too - Doctors giving support to their patients during this time of crisis may experience vicarious trauma listening to those stories. Don't forget, you can contact the Queensland Doctors' Health Programme's (QDHP) 24/7 confidential Helpline on (07) 3833 4352 for peer-to-peer assistance and support. The QDHP is manned by trained GPs and counsellors who stand ready to assist.

The Medical Benevolent Association of Queensland (MBAQ) can also provide financial assistance to doctors who are facing adversity and loss of income: https://mbaq.org.au/

Support with membership fees - If you are experiencing financial difficulty as a result of the bushfires, please contact us at membership@amaq.com.au.

AMA Queensland is here to support you and your colleagues - Please do not hesitate to contact for support and advice over the coming days and weeks.

Dr Dilip Dhupelia, President AMA Queensland

The Medical Journal of Australia • MJA
MEDIA RELEASE

IN-HOSPITAL ASSESSMENT OF DIABETES STATUS: MORE SUPPORT NEEDED

BLOOD glucose and HbA_{1c} screening alone does not improve diabetes case detection and care for patients admitted to hospital from emergency departments, according to research published today by the *Medical Journal of Australia*.

Researchers from hospitals and universities across New South Wales, set out to determine whether routine blood glucose assessment of patients admitted to hospital from emergency departments (EDs) resulted in higher rates of new diagnoses of diabetes and documentation of follow-up plans.

Blood glucose was measured in 133 837 patients admitted to 18 NSW public district and tertiary hospitals from an ED between 31 May 2011 and 31 December 2012, with outcomes followed up until 31 March 2016. The hospitals were randomised into the intervention group and control group. Routine blood glucose assessment was done at both the control and intervention hospitals. In the intervention hospitals automatic requests for glycated haemoglobin (HbA_{1c}) assessment and notification of diabetes services for patients with blood glucose levels of 14 mmol/L or more were undertaken.

The numbers of new diabetes diagnoses with documented follow-up plans for patients with blood glucose levels of 14 mmol/L or more were similar in the intervention (83/506 patients, 16%) and control hospitals (73/278, 26%), as were new diabetes diagnoses with or without plans (intervention, 157/506, 31%; control, 86/278, 31%). Thirty-day re-admission (31% v 22%) and post-hospital mortality rates (24% v 22%) were also similar for patients in intervention and control hospitals.

“Adding automatic requests for HbA_{1c} assessment and notifying diabetes services at intervention hospitals did not lead to a higher proportion of patients receiving new diabetes diagnoses or plans for diabetes follow-up, nor did it significantly affect patient outcomes,” wrote the authors, led by Professor N Wah Cheung, from the University of Sydney and a senior staff specialist at Westmead Hospital.

“Hospitalisation provides an opportunity for diagnosing previously unrecognised diabetes in patients. The incidence of new diabetes diagnoses in our study was comparable with that of older studies, in which 20–42% of hospital patients with newly documented hyperglycaemia were further investigated or received an intervention.

“Our results suggest that routine blood glucose testing of patients admitted from EDs, an inexpensive intervention, can identify some patients with unrecognised diabetes.

“However, they also indicate that routinely requesting HbA_{1c} assessment of ED patients, without well developed and adequately resourced plans for their management and referral, does not lead to increased diagnosis of diabetes or better hospital outcomes for admitted patients.”

Cheung and colleagues reported that the UK had recognised that greater investment in inpatient diabetes services and training was needed to improve outcomes in 2001 by publishing a National Service Framework for Diabetes that incorporated service planning objectives for inpatients with diabetes.

“Similarly, NSW Health established the NSW Diabetes Taskforce in 2016, developing training resources, tools for supporting local auditing of inpatient diabetes care, and standardised processes for identifying people with diabetes in hospital, including blood glucose screening,” they wrote.

“It remains to be determined whether greater emphasis on training elements in the glucose screening program can improve outcomes without additional staff resources or specialist inpatient diabetes teams being provided.”

Please remember to credit *The MJA*.

The *Medical Journal of Australia* is a publication of the Australian Medical Association.

The statements or opinions that are expressed in the MJA reflect the views of the authors and do not represent the official policy of the AMA or the MJA unless that is so stated.

The Medical Journal of Australia • MJA
MEDIA RELEASE

CALCIUM SUPPLEMENTS HAVE "VERY LITTLE PLACE" IN MODERN MEDICINE

EVIDENCE suggests that calcium supplements have "very little place" in modern medical practice, according to the authors of a narrative review published today by the *Medical Journal of Australia*.

Professor Ian Reid, Professor of Medicine and Endocrinology, and Associate Professor Mark Bolland, both from the University of Auckland, reviewed the evidence of both efficacy and safety of calcium supplements, and vitamin D supplements.

"The use of calcium supplements in individuals without specific bone pathology does not have a sound evidence base, and the safety concerns suggest that the net effect could be negative," Reid and Bolland wrote.

Calcium supplements, they wrote, are frequently associated with gastrointestinal symptoms, particularly constipation, and they have also been reported to double the risk of hospital admissions related to abdominal symptoms.

"In the Women's Health Initiative study, calcium and vitamin D increased the risk of renal calculi (kidney stones) by 17%. There is evidence that calcium supplements increase the risk of myocardial infarction and, possibly, stroke, although this remains subject to controversy," they wrote.

Vitamin D supplements rarely cause symptomatic adverse effects, but there is evidence that vitamin D doses of 4000 IU/day, 60 000 IU/month, or 300 000–500 000 IU/year may increase the risk of falls and/or fractures. At lower levels -- doses of 400–1000 IU/day – bone benefits from vitamin D are met, "therefore, the use of higher doses is not appropriate".

There are conditions for which calcium and vitamin D supplements are appropriate.

"There are some medical conditions, such as osteomalacia, for which calcium and vitamin D supplements are central to management," Reid and Bolland wrote. "Their use as adjunctive therapy in osteoporosis has been the convention, but … there is little evidence that this alters outcomes.

"The use of supplements of vitamin D in patients at risk of vitamin D deficiency who need potent antiresorptives is appropriate. Calcium supplements in this context are currently accepted practice, and the safety and efficacy of romosozumab have not been demonstrated without them.

"Clinically significant vitamin D deficiency (ie, nadir 25(OH)D < 30 nmol/L) is common among individuals with minimal sunlight exposure, such as frail older people and those who are veiled, as well as in people from Africa, the Middle East and South Asia living at high latitudes," they wrote. "Supplementation of frail older people is widely advised, and also frequently provided for immigrant communities, particularly children, including those being breastfed.

"Vitamin D supplementation sufficient to raise 25(OH)D levels above 40–50 nmol/L is advisable; 400–800 units per day is usually adequate, unless there is some coexistent medical problem, such as malabsorption. Supplementation should be continued for as long as the cause of vitamin D deficiency (eg, low sunlight exposure) is present.

"Supplements have value in overtly deficient individuals, but not across the healthy older population. Based on the consistency of the data, we believe that a recommendation not to provide supplements routinely to healthy older individuals can be judged to be evidence-based … and no longer a matter of controversy.

"In summary, small doses of vitamin D have a place in the prevention of osteomalacia in individuals with specific risk factors. Calcium supplements have very little place in contemporary medical practice."

Please remember to credit *The MJA*.

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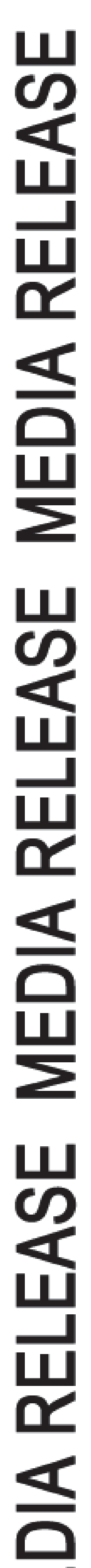

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AGED CARE ROYAL COMMISSION INTERIM REPORT CONFIRMS THE WORST – CARE CAN'T WAIT

The Royal Commission into Aged Care Quality and Safety's interim report has confirmed everybody's worst fears about the poor care, neglect, and abuse that has been occurring unchecked in Australia's aged care system for years.

AMA President, Dr Tony Bartone, said today that the Royal Commission's report is a call for action – urgent action.

"Care can't wait. We have to put the care back into aged care," Dr Bartone said.

"The Royal Commission has exposed numerous examples of neglect, abuse, mismanagement, under-resourcing, and under-funding in aged care.

"It has also given us insights into the failures of successive Governments to fix the system.

"The background papers and reports produced by the Royal Commission have highlighted how Australia compares poorly internationally in terms of staffing in aged care, and it makes for troubling reading.

"Tragically, it has told us that in a single year an estimated 16,000 people died waiting for a home care package.

"The wording of the interim report comes as no surprise to AMA members who work in aged care and witness the aged care crisis daily.

"A lack of funding, low support from providers, and little action by Government has led to the current crisis."

Dr Bartone said the AMA welcomes the call for immediate action to reduce the waiting times for home care packages.

"The AMA has been calling for this for some time," Dr Bartone said.

"Funding is needed to clear the backlog of almost 120,000 people waiting for a home care package at their approved level. It is unacceptable that people have to wait for over 12 months for a Level 4 home care package.

"A call for the reduction of over-reliance on chemical restraints is welcomed by the AMA.

"Our longstanding position is that restrictive practices should always be considered a last resort – where and when any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained.

"The decision on the use of restraints should always be made on a case-by-case basis.

"However, there must be a balance between the need to ensure the older person's safety, and the safety of those around them, including other residents and their families and friends, while respecting their right to dignity and self-determination, including acknowledging previously expressed or known values or wishes.

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"But clearly, as part of reducing the inappropriate use of chemical restraints in aged care, there must be sufficient numbers of staff and an appropriate mix of skilled staff available at all times.

"Registered nurses must be available on site 24/7 to ensure appropriate care, including the safe administration of medicines, is provided for elderly and frail patients.

"Staff must be trained to better care for residents living with dementia. Currently, that training is inadequate.

"There is plenty of evidence that improved dementia management and behavioral training for nursing and personal care staff will lead to reduced prescription of antipsychotic medications.

"Staff also need training to understand the ethical, medical, and legal issues and responsibilities when using restraints. The AMA has called for a mandatory minimum qualification for personal care attendants."

Dr Bartone said that a safe and quality skills mix of medical, nursing, and care staff, and minimum staff-to-resident ratios must be priorities.

"It is totally unacceptable that in 21st century Australia more than half of all aged care residents live in facilities that have unacceptable staffing levels," Dr Bartone said.

"We have a sad and unacceptable situation where more than 80 per cent of staff say they don't have time to provide social and emotional support to the residents."

The AMA also welcomes the call to stop the flow of younger people entering aged care. Aged care facilities are not appropriate places for younger people.

Dr Bartone said that doctors who visit aged care facilities and witness the environment experienced by young people consider it demeaning and humiliating.

"The Government must urgently explore other options and provide alternatives for younger people with disabilities who are currently residing in residential aged care facilities," Dr Bartone said.

"The Royal Commission has done an excellent job bringing to light the national shame of what is happening in aged care. We applaud the work of the Commission – but we cannot wait another year or more to start to fix things.

"The Government must act now – immediately. It cannot hide. No ifs, no buts, no more excuses. Our parents, our grandparents, our friends and loved ones deserve better. Care can't wait."

---

1 November 2019

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HOI AN VIETNAM by Cheryl Ryan

The ancient city of Hoi An located on the South China Sea Coast is the centre point of the J-shaped country Vietnam's coastal stretch and a UNESCO World Heritage Site for the past two decades.

The city is a classic example of an Asian trading port of the erstwhile centuries and an amalgamation of local and foreign architecture. A melting pot of the Chinese, Vietnamese, Japanese, French and thereby enriched with a diverse culture the city is bound to leave you awestruck.

Must-Try Dishes in Hoi An

You will find a wide array of restaurants and street stalls offering delectable Vietnamese cuisine which go beyond the customary noodles and rice. Try their Banh Bao Vac (White Rose shrimp and pork dumplings), Banh Xeo (crispy pancake), Banh Mi (Vietnamese Baguette), Ca Phe (sweetened condensed milk coffee), Mot Tea (an iced herbal tea), Tube Popsicle and Vietnamese Donut to enjoy the fresh finger-licking goodness of their delicacies!

What Have We Planned For You

- Glide down the region's most important river – The Thu Bon River – in a kayak or a motorboat and admire the pristine waters and natural surroundings.

- Be sure to take your vacation around a full moon so you could witness the popular Hoi An Lantern Full Moon Festival. It is a celebration by the local people meant to honor their ancestors. Observe how the locals exchange candles, lanterns, flowers and fruits to bring in prosperity.

- Take a walking tour to soak in the old world charm the city exudes and marvel at the traditional wooden buildings alongside French colonial architecture. Stop by at local restaurants to sample the authentic Vietnamese fare or shop for souvenirs, fabrics, lanterns and handicrafts at the night bazaars or the street hawkers.

- Visit the famous Japanese Bridge built over the river to connect the Japanese settlement with the Chinese living across the river back then. It is a hallmark of traditional Japanese architecture and connects two separate shopping areas in the present day.

- Enroll for a half-day, full-day or evening cooking course conducted by local restaurants. The reasonably priced course will teach you to toss up the most exotic Vietnamese dishes in a jiffy.

Some courses also include a visit to the local market for buying fresh produce for your dishes.

This colorful and peaceful city lives up to its name Hoi An meaning – peaceful meeting place!

Cheryl Ryan -123Travel

www.123Travelconferences.com.au

123 TRAVEL CONFERNCE

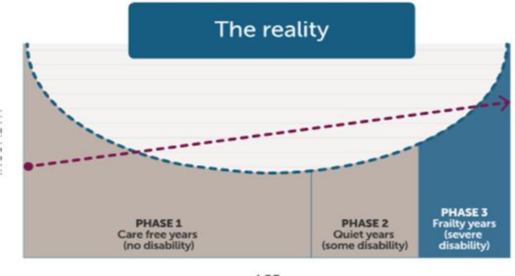
The hidden cost of retirement

The common question when it comes to retirement is 'how much is enough?'.

If only the answer was simple! But the fact is that the answer varies due to a range of factors, including your lifestyle aspirations, personal health and family commitments. But regardless of how much you have put aside, there's a significant potential cost in retirement that is often not considered, and if ignored, it can undermine our plans - aged care.

None of us want to imagine a time when we are no longer able to look after ourselves without assistance. But the reality is that around one quarter of our retirement may be 'frailty years', where help is needed with the activities of daily living.[1] Planning ahead for this time allows you to maintain greater control of your life, so that your choices – for example, home care versus residential care – can be respected. But it all costs money.

While lifestyle spending does tend to reduce as we progress through retirement, expenses can ramp up again during the "frailty" years – on average, the last three to five years of life, generally after age 80. It is during this phase that we are likely to have some form of disability caused by ageing which causes a general decline in independence. And we may become more reliant on others.



The spending pattern in retirement will vary based on your ability and it looks more like a smile than a straight line.

Increasing longevity and expectations around the quality of care are also putting greater pressure on income needs in the later phase of retirement.

Because aged care is expensive, the government subsidises the costs, but you will still need to pay some of the costs – based on your assessed level of affordability. Access to capital or income at this time may allow you to have greater choices and control over the quality of your care, which is why planning for the cost of future care is critical to include in your retirement planning, and long before a crisis arises.

Having a financial plan in place that clearly captures your goals, preferences and financial strategies, is a great way to keep on track throughout all phases of retirement.

If you want to review discuss your retirement plans or how to start planning for your frailty years, please feel free to give us a call with your questions.

Kelly Brady – Poole & Partners Investment Services Pty Ltd   phone 07 54379900

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NEW FUNDING MODEL FOR ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES A POSITIVE MOVE

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Today's announcement of a new funding model for the Aboriginal community controlled health sector is a positive recognition of the critical role the sector plays in the wider health system, AMA President, Dr Tony Bartone, said.

Health Minister Greg Hunt announced the new Indigenous Australians' Health Programme (IAHP) funding model, and additional funding of $90 million over three years for Aboriginal Controlled Community Health Services (ACCHSs), at the National Aboriginal Community Controlled Health Organisation (NACCHO) conference in Darwin.

"The AMA welcomes Minister Hunt's announcement.

This funding will ensure that ACCHSs continue to receive the funding they need to provide quality, comprehensive, and culturally safe primary health care," Dr Bartone said."Importantly, this funding also gives services certainty about their funding for the next three years, providing stability to the sector.

"It is positive to see the Government's recognition of the critical role that the Aboriginal community controlled health sector plays in Australia's health system.

"We know that Indigenous people have a greater chance of improved health outcomes when they are treated by Indigenous doctors and health professionals. They are more likely to make and keep appointments when they are confident that they will be treated by someone who understands their culture, their language, and their unique circumstances.

"The AMA has a strong commitment to achieving improved health and life outcomes for Aboriginal and Torres Strait Islander people in Australia, and has advocated for more Commonwealth investment in health services.

This includes urging the Government to reverse the funding freeze for ACCHSs in the 2018-19 Federal Budget, and urging Governments to commit to a capacity-building fund of $100 million over four years to fill service gaps.

"Closing the disgraceful gap in life expectancy and health outcomes between Indigenous and non-Indigenous Australians requires real action from all levels of Government, the private and corporate sectors, and all segments of our community."

The IAHP model was developed in collaboration with the sector through the Comprehensive Primary Health Care Sustainability Advisory Committee, of which the AMA is a member.

6 November 2019
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Notice to New and Past Members

Don't waste time! Join now!

CPD Points Certificate Available

RDMA END OF YEAR NETWORKING FUNCTIONS

Get Your Membership Benefits! Socialise! Broaden your Knowledge!

Dear Doctors

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

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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"The Uncle We Never Knew"

https://www.awm.gov.au/articles/blog/remembering-Ivor-Whittaker by Clare Hunter

More than 75 years after her older brother disappeared while gathering intelligence during the Second World War, Marcelle Price's family gathered at the Australian War Memorial in Canberra to attend a Last Post Ceremony commemorating his service and sacrifice.

For Marcelle, who turned 100 this year, it was a particularly special moment to know that her beloved brother, Ivor Whittaker, was being remembered at the Memorial.

In September 1941, Ivor was on a reconnaissance flight that went missing over the Mediterranean. He was declared missing, presumed dead, but his body was never found.

The news was a devastating blow for the family, who continued to hold out hope that he would be found alive. "It must have been devastating when Ivor went off to war," Marcelle's daughter Jocelyn Henry said after the ceremony. "It was a very close family … [and] they were very proud of him, but I remember them saying for a long time it was very hard not knowing what had happened to him."

Jocelyn never met her uncle, but she grew up hearing stories about him from her mother and her grandparents. "One of my brothers referred to him as the uncle we never knew," she said. "But I think all of us felt that he'd been quite a role model for us."

Ivor Whittaker was born on 14 August 1910 in Brunswick, Victoria, to Robert and Muriel Whittaker. He had two younger sisters – Shirley, who was born when he was four years old, and Marcelle, who was born when he was seven – and was educated at Scotch College and Melbourne University.

"Everything he turned his hand to he did very well," Jocelyn said. "He was a prefect, school captain, school pianist, captain of rowing and the football team, and was dux of mathematics."

He was also a noted skier, representing Victoria and becoming a founding member and president of the University Ski Club. In 1931 he won the prestigious Silver K trophy in Switzerland. In line with his passion for skiing, Whittaker was an expert accordion player, performing a range of Swiss and Austrian skiing songs at ski lodges in the evenings.

"He was very sociable," Henry said. "He played his squeezebox, as they called it, and being able to play by ear he would have been in demand to play the piano."

Ivor Whittaker was on a reconnaissance flight when it went missing over the Mediterranean.

Whittaker began his military career with the Scotch College Cadet Corps and joined the Melbourne University Rifles while studying commerce. He even served as a guest officer in an English regiment on Salisbury Plain during an overseas visit.

By the age of 25, he was secretary of the family business, Whittaker Clothing, and had visited clothes manufacturers as far away as New York and London to study their practices.

His sister Shirley, who was a promising tennis player, died in June 1939 after suffering a long illness.

When war broke out in Europe a few months later, Whittaker was one of the first to join up, enlisting in the Second Australian Imperial Force in October 1939. He was given the enlistment number VX24 and was appointed as an intelligence officer with the 17th Infantry Brigade, part of the 6th Division.

After attending Staff and Command School in Sydney throughout December, Captain Whittaker became engaged to his sweetheart Margaret Symons before joining his unit at Puckapunyal in Victoria in February 1940.

The 17th Infantry Brigade left Australia on 14 April 1940, arriving in Kantara, a town on the western side of the Suez Canal, in May. He gave lectures on map reading during the trip and was later injured in a head-on car crash in Libya while working as an intelligence officer for the 17th Brigade. He was reportedly taking information to a general who was captured just a few hours later. **To Be Continued Next Month**