RDMA
RDMA & NLMA's Joint Newsletter

Newsletter
FEBRUARY 2018

Redcliffe to Urluru-Ayres Rock & Back by Peter Stephenson

See Where We Work & Live on pages 16 and 20.

President's Report Dr Kimberley Bondeson

Welcome to 2018, hot weather and thunder storms.

Hopefully there will be positive changes for this year. If the current stormy weather is anything to go by, then this year is going to be one of surprises.

There is to be an election for a new AMA Federal President, and our very own Dr Gino Pecoraro is standing for AMA President. Dr Pecoraro is a local Brisbane Gynaecologist and Obstetrician, and past AMAQ President. He is passionate about medical issues, and will be focusing on increasing the indexation of Medicare rebates and hospital funding. He is a skilled communicator, with TV and radio experience.

Other contenders are Dr Tony Bartone, a Melbourne GP, who is currently the vice president, and Professor Brad Frankum who is the current NSW AMA President. All would bring excellent skills to this position.

Dr Geoffrey Hawson has compiled an excellent report (see further) on "Attitudes to Retirements and Registration – Survey Results". I highly recommend that you read his article, which was prompted by dissatisfaction with the current constraints on retired doctors, and this warranted further investigation by RDMA members, along with NLMA and Sunshine Coast LMA members.

The Survey Monkey was designed and launched, and Dr Hawson has presented the results. Now, the members need to decide on what further action they want, as well as what format they would like any proposed changes to take.

A hot topic is "The chilling case of Dr Bawa-Garba" who was charged with manslaughter of a young patient, and whose name has been erased from the medical register in the UK.

Is this the new face of medicine, where a doctor, trying to do her/his job, is charged with manslaughter? The story reads like a comedy of errors, with a tragic outcome. There is an effort to have these charges overturned, which I support, as I simply do not believe, from the details available on this case, that this doctor committed manslaughter.

I would also like to welcome Dr Paul Bryan, Vice President who has joined the NLMA executive, at their most recent AGM.

Welcome Paul, along with the other executive members, Dr Bob Brown, who was voted in again as President, and Dr Graham McNally, Treasurer and Dr Ian Hadwin, Secretary, all voted in unopposed.

Kimberley Bondeson,
RDMA President

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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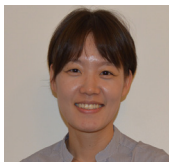

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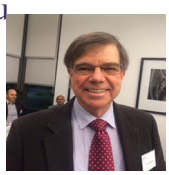

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RDMA 2018 MEETING DATES:

For all queries contact 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

NEWSLETTER DEADLINE

Advertising & Contribution 16 March 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	11th OR 14th

Next Meeting Date 27th February 2018

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 27th of February 2018**

TIME: 7pm for 7:15pm start

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

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

AGENDA:

7:00pm	Arrival & Registration
7:15pm	Be seated – Entrée served Welcome by Dr Kimberley Bondeson – President RDMA Inc
7:20pm	Sponsor: Mundipharma
7:25pm	Speaker: Dr Geoff Harding, Director Sandgate Spinal Medicine Clinic - Topic: Chronic Pain Management - Post Codeine Rescheduling
8:15pm	Main Meal served
8:25pm	Question Time
8:35pm	Speaker: Dr Bill Boyd-President of AMAQ
8.45pm	Dessert, Tea & Coffee served
8.55pm	General Business

RSVP: By Friday 23rd of February 2018
(e) RDMA@qml.com.au or 0466 480 315

INSIDE THIS ISSUE:

Competitive Advertising Rates:

Full page A4: $560.00
Half page A5: $330.00
Qtr page A6: $260.00
Business Card size (new): $70.00
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.

RDMA COMMITTEE MEMBER
DR GEOFF HAWSON MBBS FRACP FACHPM DIPCLINHYP

ATTITUDES TO RETIREMENT AND REGISTRATION: SURVEY RESULTS

Attitudes to Retirement and Registration: Survey Results

Background

Against a backdrop of government initiatives to enable prescribing rights for allied health practitioners (for example, rights for physiotherapists "to prescribe scheduled medicines for the management of pain in patients presenting with musculoskeletal and/or spinal conditions to emergency departments or specialist outpatients screening clinics") and the expansion of the scope of practice for a range of non-medical health practitioners to include medical advice, referrals for MRI, and blood profiles[1], there has been ongoing discussion of how senior/retiring doctors can continue to contribute to the profession, particularly given the abolition of the Limited Registration Public Interest Occasional Practice (LRPIOP) for retired doctors. Following on from a recent article on registration requirements in the July 2017 RDMA newsletter and a subsequent talk to members by Geoff Hawson, a proposal to survey members was taken up by the RDMA committee.

Survey and Sample

A preliminary set of draft questions was developed by Larry Gahan and reviewed by the RDMA committee. Peter Stephenson organised for the final set of 10 questions to be circulated via Survey Monkey to members in three districts – Redcliffe and District (130 invitations), Sunshine Coast (391 invitations) and Brisbane Northside (91 invitations). Members of RDMA and SCLMA were sent a link to the survey. There were 106 combined respondents (45 RDMA, 35% response rate; 61 SCLMA, 16% response rate). Unfortunately, the free version of Survey Monkey limited the number of reported responses to 100 per survey and responses from 6 Sunshine Coast LMA respondents were not included in the Survey Monkey report. It is unknown which respondents were excluded. Once the limit was realised, a separate survey link was sent to Northside (NLMA) members with the same survey questions (31 respondents, 34% response rate). The total number of respondents was 131.

Survey Questions

The survey questions covered age; time to retirement; awareness of full registration requirements and their implications for retirement and the practice of medicine; registration status; whether loss of registration and associated privileges at retirement is of concern; awareness of the AHPRA definition of practice; awareness of requirements for recency and CPD; whether 'limited registration in retirement' should be considered; and if so, what aspects of practice should be preserved. A final question invited comments. This article predominantly reports on responses to the first 9 survey questions. Where relevant, member comments have been included to add dimension to the quantitative results. A more complete analysis of repondents' comments will be presented in a follow-up article.

Respondent Characteristics

Age

- The table below shows distribution of the sample by age (Q1, n=131).

< 40 yrs	40-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	Over 80 yrs
6%	11%	21%	34%	26%	2%

Registration

- 77% held current registration while 23% were retired (Q2, n=118). Of those with current registration, 69% held specialist registration and 31% held general registration (Q4, n=126)).

Time until retirement

Not considered	10-20 yrs	5-10 yrs	1-5 yrs	<1 yr
19%	18%	9%	24%	6%

CONTINUED ON PAGE 6

- Of those with registration, 30% expected to retire in less than 5 years (Q2, n=118) while 37% had not considered retirement or viewed it as longer term (10-20 yrs).

Awareness of registration requirements and AHPRA definitions of practice and recency

- 75% indicated they were aware of the current requirements for full registration (Q3, n=119). (A link to the RDMA newsletter article was included with this question).
- 62% of respondents indicated awareness of the AHPRA requirements/definitions of practice (Q6, n=121)).
- 78% reported awareness of the recency requirements of AHPRA (Q7, n=120).

These definitions are provided below[2]:

AHPRA Definition of practice: Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

AHPRA Recency requirements: To meet the revised standard, you must practise within your scope of practice at any time for a minimum total of four weeks full-time equivalent in one registration period, which is a total of 152 hours, or 12 weeks full-time equivalent over three consecutive registration periods, which is a total of 456 hours. Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours.

Key Findings

Concern with loss of registration

- 71% of respondents were concerned with loss of registration privileges on retirement (Q5, n=121).

Respondent comment:

We need to continue to work towards a more sensible plan, which allows retired doctors to continue to contribute to the profession.

Preference for limited registration as a transition to full retirement

- A large majority of respondents (88%) believed that a "limited registration" should be considered (Q8, n=121).

Respondent comments:

There needs to be a scaling down from full on, all costs and bells and whistles to an intermediate with less costs, requirements, CPD, indemnity, and allowed activities, then to no activity whatsoever to practice. It was too hard to procure and maintain the qualification to just give it away.

Why do we have to stop completely if we are competent and not dangerous?

DR GEOFF HAWSON'S: ATTITUDES TO RETIREMENT AND REGISTRATION: SURVEY RESULTS CONTINUED FROM PAGE 6

Aspects of practice considered important to preserve

- Over 70% of respondents indicated that referral rights were important to preserve (Q9, n=

Referrals to Specialists	Pathology Referrals	Radiology Referrals
79%	73%	72%

- Over 60% considered prescription rights to be important to preserve.

New and ongoing repeat prescriptions	Ongoing prescriptions
60%	73%

Respondent comments:

It is ludicrous to think that before a date of retirement one has unlimited rights yet one day later none.

Unfortunately, there was an element of ageism involved with the decision to curtail retired doctors' ability to write prescriptions and referrals.

Scope of Practice

- 17% of respondents indicated that their full scope of practice in the field should be preserv while 39% indicated a reduced scope of practice could apply (Q9, n=113).

Reduced Scope of Practice	Full Scope of Practice
39%	17%

Continuing Professional Development

- 72% of respondents indicated that limited registration should involve maintenance of standards and competency through Continuing Professional Development (CPD) (Q9, n=1

Reduced CPD	Full CPD
59%	13%

Respondent comments:

I keep up to date and attend clinical conferences. My long experience in surgery helps younger colleges (70-79 yrs, retirement consideration 1-5yrs).

I am 72 and work 12 hours/week as a Specialist GP. I do a lot of Aviation medicals. I keep up all my recency requirements and CPD through ACRRM, as well as aviation education requirements from CASA. I am a medical examiner for Australia, NZ, Canada, USA and South Africa. I would like to continue doing this. (retirement consideration 1-5 yrs).

We need to keep up to date if we are to be allowed to continue practicing (60-69 yrs, retirement consideration 5-10yrs).

A large majority of survey respondents in this exploratory study agreed that 'limited registration in retirement' should be considered and that referral to specialists, pathology and radiology, and prescription rights should be preserved. It was acknowledged that 'limited registration' should involve maintenance of standards and competency through continuing professional development, although at a reduced number of hours. A majority of respondents were concerned by the loss of registration privileges with comments indicating a desire to continue contributing expertise and experience.

How a step-down approach to registration could be achieved and what this might entail need to be explored with members. Reference to other professions that recognise and encourage the active participation of retired members could inform policy in this area. For example, retired lawyers in Australia are being actively encouraged to take on pro bono work in the community with free practising certificates issued by state law societies as a consequence of advocacy and recommendations contained in the Productivity Commission's Access to Justice Arrangements Inquiry Report[3].

Survey questions could be further refined and expanded to address issues around recency, definition of practice, and CPD requirements (e.g., number of hours) in relation to retirement and to explore possible components of a limited or step-down registration. It is proposed that a more comprehensive survey at a national level be conducted.

1. Ministerial Taskforce on health practitioner expanded scope of practice. Implementation phase completion report, Allied Health Professions' Office of Queensland, December 2016. https://www.health.qld.gov.au/__data/assets/pdf_file/0028/652744/MT-completion-report.pdf

2. http://www.ahpra.gov.au/search.aspx?q=recency%20of%20practice; http://www.medicalboard.gov.au/Registration-Standards.aspx

3. Engaging Retired and Career-Break Lawyers in Pro Bono, National Pro Bono Resource Centre, February 2010.

http://www.probonocentre.org.au/apbn/nov-2015/free-volunteer-practising-certificates-now-available-five-jurisdictions/

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Open Referrals To Specialists, Codeine Prescribing Changes, After Hours Doctors Advertising Restrictions.

Well to 2018, A New Year.

Private health Insurance companies want patients to have ''open referrals'' to specialists, so that they can ''specialist shop'', without the patient having to return to their GP for a further referral.

There are simple reasons why this is not a good idea. The first, a specific specialist who the patient is referred to is normally decided upon based on the appropriate skill set of the specialist, and certainly the location of the specialist.

Sending an 80yo into the city, a long and tedious journey, to see a specialist who is readily available locally is not even sensible.

Secondly, the patient already has the option of using the referral they already have to see a second specialist if they chose, without the need for changing the named referral.

Something that patients and obviously insurers do not seem to grasp.

However, often the specialist themselves will request that the patient see theIr GP for a new referral – and again, the reason behind this is simple. Is that specialist the most appropriate for that patient?

And finally, is Medicare really going to fund multiple referrals to specialists for the same problem?

The Codeine Prescribing changes have come into effect, and despite the Pharmacy Guilds warnings, there had not been a "patient stampede", and there has not been a shortage of doctors' appointments.

The GP waiting rooms are not filled with patients in debilitating pain, flooding GP waiting rooms across Australia.

This is definitely ''media hype''. It will be interesting to see what unfolds over the next few months.

After hours doctors advertising restrictions are coming into place.

Changes, introduced from the `1st of March ban providers from all direct marketing to consumers, including social media, texts, emails, TV, radio and print advertising.

If they fail to comply, the government can strip them of their right to employ non-VR doctors, under the Approved Medical Deputising service Program.

They are, allowed to run websites, but they must be directed at GP clinics.

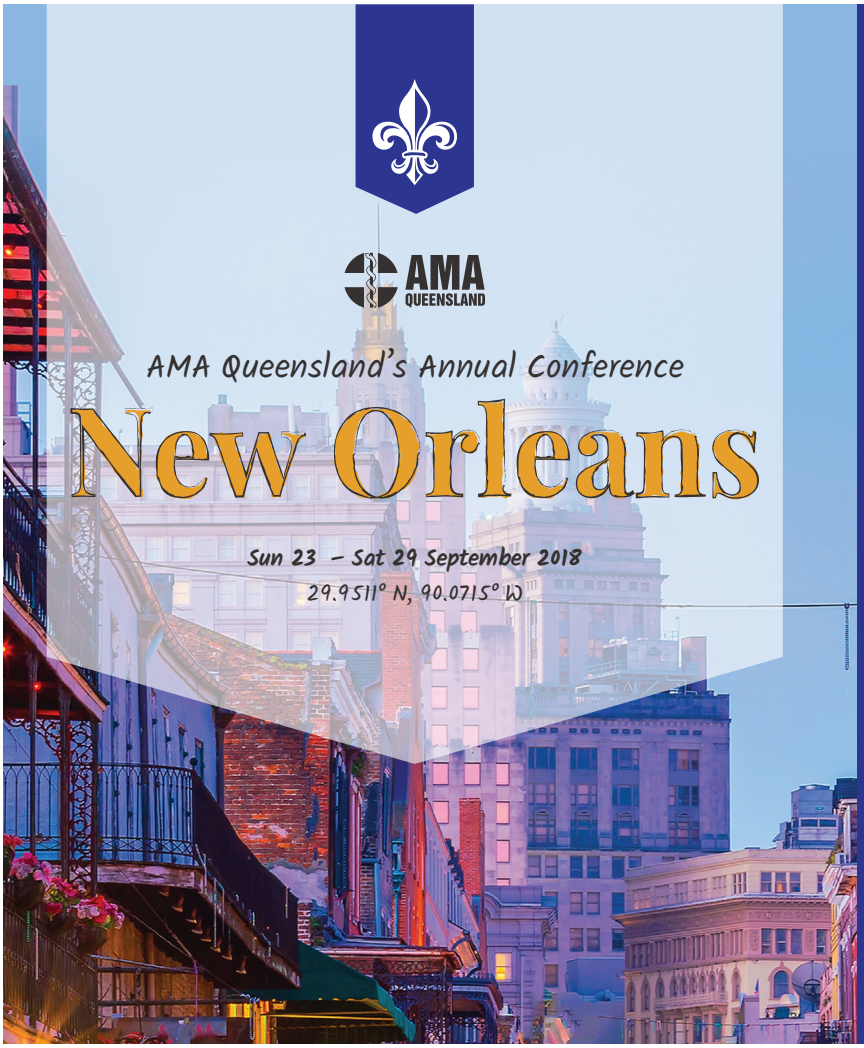
The new rules outlined by the health department, also ban after-hours doctors from writing any prescriptions without the consent of the regular GP.

This aspect of the industry was caused by the massive increase in ''urgent'' after hours doctor call outs, and has not been made any easier by the fact that one after hours doctors group paid for 10,000 of their patients to spend a weekend at Dream World, as a thank you for their ''loyalty''.

This ''marketing ploy'' has definitely upset Health Politicians, who see as a waste of Medicare money.

Sincerely

Kimberley Bondeson



Doctors, practice managers, registered nurses and other medical industry professionals from around Australia are invited to attend the ***Annual AMA Queensland Conference*** **in New Orleans from 23-29 September 2018**.

The program will feature high-profile American 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

Qscan
RADIOLOGY CLINICS

Qscan North Lakes New PET-CT Service

PET-CT services run by **Dr Phillip Law** (MBBS (UNSW), FRANZCR, FAANMS) local Qscan Oncologic Radiologist.

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CEO UPDATE:

AMA Queensland

LMA NEWSLETTER COLUMN – FEBRUARY 2018

Welcome to the new Health Ombudsman

The Queensland Health Minister has recently appointed Rachel Hunter as the new state's Health Ombudsman. AMA Queensland has been highly critical of the performance of the OHO and has long been calling for reforms to overhaul the system's current deficiencies and inefficiencies.
We look forward to working with the new Health Ombudsman on progressing urgent issues, such as constant budget overruns, investigations taking longer than their legislated timeframes and the high number of vexatious complaints, to ensure that the OHO becomes an efficient, fair and streamlined complaints management system.

MOCA 5 update

Our Workplace Relations Team spent the past six months working closely with our public hospitals members to finalise the log of claims for the upcoming Medical Officers' Certified Agreement 5 (MOCA 5) negotiations. The Team visited 12 hospital visits across the state and conducted meetings with regional, senior and junior medical officers to understand what the burning issues were for the new agreement. Along the way, more than 50 Salaried Medical Officers responded to our call to become MOCA 5 local representatives.

In January, we presented both the senior and the junior doctors' log of claims to Queensland Health and we are now working to arrange a negotiation schedule ahead of the formal bargaining period commencing this month. Read the notice of intention to bargain **here**.

We will keep you informed of progress with the negotiations. If you have any questions or concerns, please email: moca5@amaq.com.au or call (07) 3872 2222.

Your top 5 issues for 2018

Finally, calling on all AMA Queensland members - we are keen to hear from you. Tell us what are the key health policy and workforce issues you want us to take forward in 2018. If you are an AMA Queensland member, please **take the poll here.**

Jane Schmitt
Chief Executive Officer, AMA Queensland

GP Liaison Update – February 2018
Dr James Collins

Email- mngplo@health.qld.gov.au **Referral website -** www.health.qld.gov.au/metronorth/refer

The GP Liaison Service has had another busy month and I just wanted to update you on a few new resources and events coming up:

Do you have a special area of interest in General Practice?

The GP Liaison Team (mngplo@health.qld.gov.au) would like to hear from you as we're compiling a list of North Brisbane GPs who would be interested in opportunities to work with specialists across: neurology (headaches), gynaecology and contraceptive
health, endocrinology (adult and gestational diabetes), gastroenterology and renal medicine. Metro North Surgical Services would like to receive feedback regarding the management of musculoskeletal and fractures within the primary care settinghttps://metronorth.citizenspace.com/metro-north-surgical-services/f26f337e

New Health Pathways Resources

As discussed last month HealthPathways is a new GP hub developed for Brisbane North GPs to access news and local guidance for the assessment, management and services for a range of medical conditions.
For access go to: www.brisbanenorth.healthpathwayscommunity.org
To login use (case sensitive): Username: Brisbane Password: North

New Health Pathways include: Codeine - Chronic Use and De-prescribing, Hepatitis C management, Irritable Bowel Syndrome & more.

Women under 25 are no longer eligible to claim Medicare rebates for Cervical Screening

Since 1 December 2017, patients may face out of pocket expenses if they are under 25 years. See the new 'Cervical Cancer Screening' Pathway on Health Pathways for more details.

Upcoming Free GP public hospital education events

28 Feb, 7 and 14 Mar – Latest in COPD diagnosis and management. Evening ALM for GPs, Caboolture Hub, Cat 1 points- free event

21 March –Back Pain tips, tricks and a new Healthy Spine Service in Metro North, Prince Charles Hospital, 6pm

11 June – Save the date - Paediatrics GP education evening – more details to come

To register or for more information on these or future events go to www.bit.ly/phnevents

As always please let me know if you have any feedback or suggestions for the GP Liaison Service. You can contact me at mngplo@health.qld.gov.au

Health Provider Portal/Viewer now includes Outpatient Appointments

Over 260 GPs are now using Health Provider Portal (HPP)/ The Viewer in Brisbane North which includes real time pathology, radiology results, medications, discharge summaries and event summaries from any Queensland Health facility.

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 each of your practice's GPs are up to date. This can be done at www.health.qld.gov.au/metronorth/refer, and clicking *"Update GP Practice Details"* in top right corner, which will access a PDF form, with information on how to complete and return.

Once your details are up to date, a GP can register at www.health.qld.gov.au/hp-portal

For more information about signing up, download the factsheet at: www.bit.ly/HPPfactsheet
For information on how to use The Viewer/HPP go to www.bit.ly/HPPsupport

Dr Geoffrey A T Hawson
MBBS FRACP FAChPM DipClinHyp
Associate Professor (U of Q)

Medical Oncologist Clinical Haematologist
Palliative Care Physician

Cancer Second Opinion

Cancer Second Opinion is the culmination of my many years treating individuals diagnosed with cancer. My aim is to help patients be better informed and in control of their treatment path.

- Cancer second opinions
- Expert advice on cancer treatment options
- Help with understanding prognosis
- Clarification of survival rates
- Advice on the relevance and usefulness of genomic testing
- Medical hypnosis for treatment-related hot flushes, nausea and pain management
- Monitoring and treatment of non-malignant haematological conditions
- Alternative therapy monitoring

Consultations by Skype or in rooms:
1/49 Butterfield St Herston 4006
Mob 0413 720 959 | Fax 07 3177 7378
reception@cancersecondopinion.com.au
https://cancersecondopinion.com.au

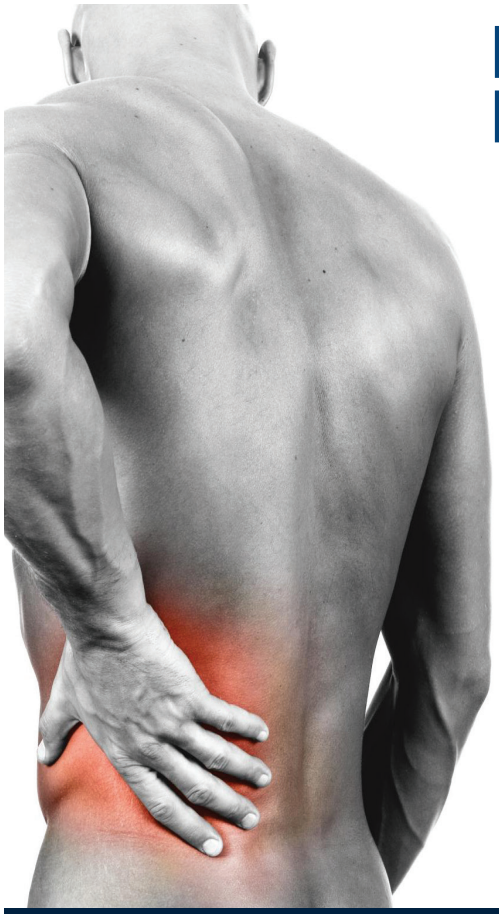
Dr Geoffrey A T Hawson
MBBS FRACP FAChPM DipClinHyp

Cancer Second Opinion

Ongoing monitoring for non-conventional therapies: Currently there is little support for individuals who choose not to have conventional treatment for their cancers. For these patients, I offer ongoing monitoring of their cancer using relevant radiology and pathology. Ongoing monitoring allows individuals access to information about their cancer over time and can be helpful in decisions about the forms of treatment to continue with, whether conventional or alternative. Early detection of disease progression is important so that second-line therapy can be considered. Sometimes choosing not to have conventional treatment is related to feeling overwhelmed by a cancer diagnosis, treatment side effects, and survival rates. Clarification of these issues and time to fully discuss options can assist patients in their decision making.

Advice on genomic testing and targeted therapies. Genomic tests can be used to identify abnormalities or mutations in the DNA of cancer cells, while targeted therapies work against specific mutations. For example, some non-small cell lung cancers are being treated with targeted therapies while other non-small cell cancers are being treated with immunotherapy. While therapies that target specific mutations in cancer genes are becoming more common not all cancer mutations are "druggable mutations", meaning that not every cancer can be treated in this way. For patients and their doctors contemplating genomic testing, I can advise on the relevance and usefulness of testing for specific cancers and whether targeted therapies are available.

Consultations by Skype or in rooms:
1/49 Butterfield St Herston 4006
Mob 0413 720 959 | Fax 07 3177 7378
reception@cancersecondopinion.com.au
https://cancersecondopinion.com.au



PHYSIOTHERAPY & CHRONIC LOWER BACK PAIN (CLBP)

Physiotherapy can help if:

The pain is thought to be mechanical i.e. exacerbated by joint & muscle tests.
The pain is aggravated by poor movement patterns or postures.
The pain persists for more than four weeks.
The chronic pain has not had an active rehabilitation program before.

What Physiotherapy actually does:

Thorough musculoskeletal assessment and analysis of faulty movement patterns and postures.
Manual therapy: to reduce pain, allowing quicker return to work and normal activities.
Home exercise programs: 'as above' puts the patient in control.
Core stabilisation training: Helps to reduce pain and prevent recurrences.
Postural and ergonomic advice: Enables a faster pain-free return to normal activities.
Graded activity and return to work plans: step by step plans to help guide patients back to their normal activities as soon as possible.
Reassurance: encouragement, advice to stay active, limit fear-avoidance behaviour.

Sports & Spinal can help
get your patients **BACK to Health**

sports&spinal™

WOOLLOONGABBA
48 Annerley Road
Ph: 3833 2555 F: 3256 3948

NORTH LAKES
Lvl 1, 9/12 North Lakes Drive
Ph: 3833 2555 F: 3256 3948

CHERMSIDE
Suite 2, 832 Gympie Road
Ph: 3833 2555 F: 3256 3948

Mental Illness and Perceptions

By Dr Mal Mohanlal

How do we define mental illness? As you know all over the world mental illness is increasing in every society. So it is very important for us to understand what mental illness is and how it comes about.

In my mind I regard mental illness as a disorder of perception. When a person becomes out of touch with reality and starts behaving in a way that is unacceptable to the rest of the community, and starts disrupting the smooth functioning of society, that person could be labelled as suffering from a mental illness.

To understand mental illness we must appreciate the fact that every one of us is a conditioned individual. This is inevitable because no matter which society one grows up in one receives a powerful conditioning effect from the cultural value system, the language and traditions of that society. It means that every one of us is brainwashed by the society we live in as we grow up. It also means that every one of us will have acquired values, traditions and beliefs of that group and have some distorted perception of reality to start with. Our perceptions then change as time and experience forces us to move on. It is up to the individual to wake up and clear up those perceptions during one's lifetime or die becoming a copy of the people around them.

Normally we all go about our daily activities despite our somewhat distorted perceptions. This is because society conditions us to think in a particular way. However this normality is relative to the society we live in. Since not all societies have the same value system, what is considered right in one society may be considered totally wrong in another society. That is our behaviour may be acceptable in one set of circumstances but may be totally unacceptable or inappropriate in another set of circumstances.

So it is the degree of distortion that determines the level at which a clinical disorder of behaviour and action will manifest itself in the individual as mental illness.

As perceptions produce physiological and biochemical changes in the individual is it not important to understand how they influence our subconscious mind and our body?

Do you know that almost 96% of the human body weight consists of only four elements, oxygen, carbon, hydrogen and nitrogen? And most this is in the form of water.

And do you know that our mind can be divided into two parts, the conscious and the subconscious? The conscious mind which most people are aware of only represents a fraction of our daily activities. Like our body weight which is mostly made up of the above four elements, over 90% of our activities are subconscious.

That is all our vital organs such as our brain, heart, liver, kidneys and lungs which keep us alive are under subconscious control. Yet no one seems to be interested in learning about how our subconscious mind works and how negatively or positively it is being influenced by our perceptions.

The fact is we live in a hypnotic world. While our conscious mind is discriminatory with our like and dislikes, our subconscious mind is like a sponge which absorbs everything in its path and will be open to all sorts of influences. It is non-discriminatory. Negative stimuli will make us feel negative and positive stimuli will make us feel positive.

Our perceptions and how they affect our subconscious mind are therefore most important in the way we feel. This is why in a consumer society the ego is being constantly exploited and pandered to by businesses, the media and the politicians so they can enhance their own interests. Yes it is a self-centred world we have created where individuals carry distorted perceptions and where responsibility for one's actions is never foremost in one's mind.

Can we therefore depend on the politicians to improve our mental health? Now politics is a game of distorting people's perceptions, not correcting them. Politicians will be the last people you turn to, to improve your mental health.

Can we depend on the media to improve our mental health? The media depends on news, gossip and sensationalism etc. to sell their product. How can these mischief makers help you improve your mental health?

The only people we can turn to, to improve our mental health are the doctors. But alas the medical profession appears to have been seduced by our consumer society and have abandoned their role of being our guardian of physical and mental health. They have turned the profession into a political bureaucratic structure where they operate closed shops and indulge in restricted trade practices in collusion with the government.

Mental Illness and Perceptions

By Dr Mal Mohanlal continued from Page 14

Like the politicians they are trying to convince themselves and the public that medicine is an exact science and can be treated as a consumer item with the same standards of measurements that apply to any consumer item. Clearly our medical leaders are misguided. These pseudo-scientists should not be playing politics and they should not be playing the sick role of Porky Pig selling pork chops and pork sausages on behalf of the government. This is not self-regulation they are practising. That is a misnomer. In my book that is the path to self-enslavement.

But just because our medical leaders are twisted in their perceptions, it does not mean the rest of the profession thinks in the same way. Doctors as a breed are mostly independent thinkers. Most of us in the profession do not follow any leader or leaders blindly and are not academically inclined. We retain healthy amount of scepticism in whatever we do. Most of us enter the profession meaning to improve the physical and mental health of people around us.

So in this day and age where there is a lot of confused thinking, anxiety and depression going on in society and if you wish to improve your mental health, I would suggest you find a good general medical practitioner you can talk to. I say General Practitioner and not a Specialist because it is the GP who has the special interest in your welfare. The Specialist does not have the time or inclination to listen to your private matters. This GP should have a common sense approach to life and must look happy and healthy. Be wary of any doctor who looks sick and unhealthy. If he cannot cure himself he cannot help you either.

Quite clearly the outside world is constantly causing our perceptions to be distorted and our sanity is being tested. Thus if you are stressed out, anxious, depressed and miserable, it means that you are suffering from distorted perceptions. It means the world is making you sick and what you need is a change in your perceptions.

Remember that if you look at a problem in the right way, there is no such thing as a problem. If you look at it in the wrong way, everything becomes a problem. So why not straighten out your perceptions and start enjoying life? You have only yourself to blame if you have not done anything about it.

The above article was published on the internet recently. There has been no response from the medical profession. It is time the medical profession realised that psychiatry is not just about labelling human behaviour into various dysfunctional categories and prescribing various medications. It is also about understanding how our subconscious mind operates. We have to look at how important distorted perceptions are in creating mental and physical health problems for the individual. From my own personal experience and observations based on scientific facts available I can see that negative perceptions will lead to thinking that is essentially negative, which in turn leads to actions and behaviour that are essentially detrimental to the individual and ultimately to society.

So if we want to improve the mental health of individuals and society and address the issue of law and order in society, we cannot afford to ignore how perceptions affect our behaviour. If we do then we are abandoning our true role in society as guardians of physical and mental health and thus being pseudo-scientists. My plea to our medical leaders in the AMA and the Royal Colleges is to think about the role we are currently playing and see if what I have written makes sense.

Our leaders have to lead from the top and not depend on other members for guidance on this issue. If we as doctors cannot correct our perceptions there is no way we can help society improve its mental health. It would be like the blind leading the blind as we become part of the problem and find ourselves in the same boat as the rest of the world rearranging the deck chairs on the Titanic.

Without self-knowledge one is like a ship without a sail or engine on the ocean of life. If you live long enough you are bound to meet some rough seas and stormy weather ahead which will force to you change your perceptions.

However by understanding how your subconscious mind operates, one can easily learn to navigate smoothly without much hassle. Read my book “The Enchanted Time Traveller- A Book of Self-knowledge and the Subconscious Mind” and discover the magic in your mind. This book should be a must read for every health professional or anyone who wants to gain insight into his own mind. Visit website: http://the-enchantedtimetraveller.com.au/

Redcliffe to Uluru-Ayer's Rock And Back! by Peter Stephenson

My daughter Anna who lives overseas, suggested that we fly to Ayers Rock for an adventure together. Timing was not the best as she only visits in December so it had to be in the summer heat. Forecasted temps in the red centre were in the low forties centigrade so we set off from Redcliffe Aerodrome in the early morning of the 18th December 2017. Weather was good and a tail wind blessed us to Roma but on the way to Charleville, the low voltage light came on. Therefore, we switched off all non essential electrical instruments and landed at Charleville as planned. There we met Peter at the fuel pump and he kindly lent us his car to tour Charleville to find a battery charger to use at our next overnight stop. This was Windorah or hopefully Birdsville if the engine starts each time. Luckily, I had purchased a new battery for the trip!

Tailwind helped us on our way again and Anna's external battery chargers kept our iPad running OzRunways for secondary navigation. Windorah came and went for a fuel stop and iconic Birdsville then came into view. We did not descend on approach as usual but switched off the engine at 6000 feet, feathered the propeller and glided down over the iconic race track. A look at the windsock revealed no wind so runway 14 was selected. The landing was hairy and another look at the windsock showed the wind was 10 knots from the north and no wonder the landing was hairy!

The temperature on the ground was as expected: a very warm 33 degrees and it stayed that way overnight but the air conditioning inside was effective. We pulled out the battery, had an excellent barramundi meal, put the battery on charge, and stayed a very comfortable night in the Birdsville Pub. The next day at 7 am, we put the battery back, refuelled and took off on runway 32 into a strong 10 knot breeze and so were expecting a head wind component across the Simpson Desert as we flew west. However, we were very pleased to have another tailwind at 6500 feet, and was it beautifully smooth!Our next stop was Mount Dare Station, on the edge of the Simpson Desert. It used to be a cattle station but has been taken over by National Parks and turned into a Hotel. www.mtdare.com.au It is owned by a great couple Graham and Sandra Scott who would like to have more fly-in visitors.

We landed on a hilltop runway (15/23) only to be told by Graham that they had another one which we had missed seeing from the air: (06/24). Graham filled us up with Mogas 98 from a drum that he uses in his Jabiru 230 that he uses to fly to Alice Springs (Bond Springs). After an early lunch, we set off for Ayers Rock, planning to refuel at the Kulgera Roadhouse, but Graham said that you had to carry fuel to the A/C across the road. (I was told that that you could taxi up to the road bowser!) Therefore, we gave the Roadhouse a miss and flew on to Ayers Rock. We thought the Rock was looming up in the distance but it turned out to be Mt. Conner (2819 feet AMSL), a flat topped mountain that erupted out of the ground. It was a most unusual, and totally different in structure to Ayers Rock (2832 feet AMSL) and the Olgas (3498 feet AMSL). Ayers Rock Airfield is 1626 feet AMSL so the Rock only sticks up about 1200 feet above the ground but is so impressive and overwhelming. It is a well deserved wonder of the world.

We flew past Ayers Rock and on to the Olgas in very turbulent air, appreciating that we were well strapped in our seats. We flew around the amazing rock formations of the Olgas and back north east on to Ayers Rock Aerodrome. Approaching the aerodrome, I switched off the engine and did some soaring only to hear that a Qantas jet was inbound on a straight in approach to RWY 31, my intended runway. I said that I would hold position till he landed which I did and was about to land when the jet back tracked instead of taking a taxiway so I had to restart the engine and wait a bit longer.

After landing, I was given direction to a bowser by the CA/GRS, a certified air/ground radio service. Not exactly air traffic control, but a service to the regular public transport aircraft. Tony Arbon, the officer on duty came over from the tower and introduced himself and requested to take a photo of our Ximango with the wings folded! (I think she looks ugly in that configuration). The ground staff and ERSA says that we have to fold the wings, as ours are 17metres and are too wide for the 15metres wide parking bays! There were not many other aircraft parked but they still insisted! Tony is an ex-flight service officer and has a website www.austairdata.com.au.He lives in **Continued P20**

Rethinking your retirement needs

If you are planning how much you need to save for retirement, don't forget to include the costs of aged care. This is not just the cost of residential care, but should also include care in the home or support services to help you live independently as you age.

Factoring in the costs of aged care is becoming increasingly important with the emergence of home care, increasing longevity (living longer) and the rising incidence of dementia. Having the capacity to pay for services increases your range of choices and your ability to retain some independence. If you ignore the costs of aged care when planning the adequacy of retirement savings, you may fall short of predicting your real retirement income needs and run out of money too early.

The costs of home care

The costs of aged care have been increasing and are likely to continue to increase at a rate higher than inflation. When planning your retirement, consider the costs that you may incur in your latter years for:

- **Home care** - home care costs can be difficult to predict and can vary from $100 a week to $5,000[1] a week depending on your care needs, family circumstances and your choice for what type of care you want. Government subsidies may help to drastically reduce the cost to you, but having adequate savings opens up the choices and ability to control the level and type of care received.
- **Capital expenditure** - to make the home suitable for you as you age (e.g. widening doorways to enable wheelchairs and ramps).

e.g.

Example: Francis is single and retires at age 67. She estimates that she will need $43,695[2] per annum in retirement indexed to inflation. Her adviser calculates that she will need to save a superannuation balance of $658,000 (based on an investment return of 6% pa and ignoring Centrelink benefits) to fund her income requirements to age 90.

Francis would prefer to keep living in her own home in her older years. If she adds in the need to pay home care costs of $26,000[3] per annum (in addition to government subsidies up to $50,000 per annum) and one-off costs of $50,000 to modify her home when she reaches age 85 (in today's dollars and indexed to inflation of 2% pa), the amount she needs to save is more like $750,678.

Her current goal leaves her short by $92,000 and her money is more likely to run out by age 87. This may also put more pressure on other family members.

Next steps

Call me today on 07 54379900 if you want to review your retirement plans and factor in the costs of aged care. Don't delay the conversation as starting sooner can increase your opportunities to meet all your retirement goals.

Yours in Aged Care

Sharon Coleman (Accredited Aged Care Specialist/ Accountant)

[1] Estimate of cost for 24-hour a day private nursing.
[2] ASFA Retirement Standard for a comfortable retirement, June quarter 2017.
[3] Assuming full user maximum contribution for home care of $14,000 per annum plus $1,000 per month additional private.

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PRODUCTIVITY COMMISSION CONFIRMS HIGH PRODUCTIVITY OF AUSTRALIA'S GPs

AMA President, Dr Michael Gannon, said today that the Productivity Commission Report on Government Services 2018 provides further confirmation that general practice is the most efficient and cost effective part of the Australian health system.

Dr Gannon said the quality and productivity of Australia's GPs is up with the best in the world.

"The Productivity Commission Report is compelling evidence that the Government must provide greater investment and support for general practice," Dr Gannon said.

"The number of GP services in 2016-17 was 6.5 per annum per head of population, which is up from 5.9 services per head of population in 2011-12.

"This reflects growing demand for GP services in the community due to the impact of complex and chronic disease, as well as an increase in GP numbers.

"There were 105.9 full service equivalent (FSE) GPs per 100,000 population in 2016-17, compared to 82.9 per 100,000 population in 2011-12.

"Around 75 per cent of patients could get a GP appointment within 24 hours in 2016-17, which is consistent with previous years.

"Significantly, cost does not appear to be a significant barrier for patients who need to see a GP, with only 4.1 per cent of patients saying that they deferred accessing GP services due to cost."

The Productivity Commission also found that patients were highly satisfied with their GPs on a number of measures, including:

- 91.6 per cent said the GP always or often listened carefully to them;
- 94.1 per cent said the GP always or often showed respect; and
- 90.6 per cent said the GP always or often spent enough time with them.

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Dr Gannon said that GPs are normally the first point of call in the health system for patients, and they provide all the care needed for 90 per cent of the problems they encounter.

"GPs are providing more services for patients as the population gets older and, despite this pressure, satisfaction with these services remains high.

"The Report also shows that Australian Government total expenditure on GPs services per person only grew by 80 cents between 2015-16 and 2016-17 - from $370.60 to $371.40.

"This highlights the funding pressure that general practice continues to operate under, and the pressing need for the Government to deliver new real investment in general practice in this year's Budget.

"A well-resourced general practice sector can help keep patients out of hospital and save the health system money.

"The Health Minister, Greg Hunt, has acknowledged this potential, and has a great personal understanding of the important role that GPs perform in the health system – and the stresses they face to meet growing public demand for their quality services.

"The next Budget is a genuine opportunity to recognise and reward quality general practice."

30 January 2018

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2) Or Emailing to GJS2@Narangba-Medical.com.au

Redcliffe to Uluru-Ayer's Rock And Back! by Peter Stephenson

Caboolture and is a FIFO every 2 weeks. Not only that, he kindly gave us a lift to our hotel, carrying our battery of course! We were in time for the sunset viewing of the rock and also able to book for the 4am start on the morning for the dawn viewing by hop-on-off bus. Both experiences were memorable and are preserved in multiple pictures. More enjoyable was the walk around the Rock after the dawn viewing which we did in 2.5 hrs instead of the published 3.5hrs as we both like to walk at a good pace. Even so, we visited all the hidden sites at the base and sat in amazing arm chairs built from naturally shaped limbs of trees; such skill!. The Rock has a magical presence about it, and just too big to photograph in any meaningful way. You just have to get up close and personal to it. No wonder the aboriginals consider it a sacred site. We had planned to climb the Rock, but it was a bit windy so it was closed. (It had been open the day before.)

After our walk, we had breakfast at the Cultural Centre and returned to our hotel by the hop-on bus to check out and laze about by the pool. We were given a lift to the aerodrome by one of the hotel porters. He even carried the battery to the gate! We took off and headed back to the Rock and more pictures of it from the air for 30 minutes. I had considered switching of the motor again and actually soar over the rock but the aerodrome is 11 nautical miles from the Rock and being a true glider pilot, I don't ever trust my engine to restart! While flying backwards and forwards in front of the northern face of the Rock while my co-pilot took pictures, I inspected the overgrown remains of a runway right beside the rock. In the old days, soaring over the Rock was the norm. The old resort to the east of the rock (Mutit Julu), is now a no fly zone as the local aborigines have taken it over, so flying around the Rock is not encouraged and helicopters are such noisy creatures! Helicopters were very active while we were there.

After we had enough pictures, we set off back to Mt. Dare, passing Mt. Conner again. After landing on their other strip, I took Graham up for his first glider flight and to cancel my SAR (search and rescue) time as I could not get any reply from Centre. We climbed to 4000 AMSL (3500' AGL) and was unable to contact anyone, even to give a relay. By the time we got back to the Hotel, Canberra had already been notified and had rung the hotel with relief to hear that we had landed safely.

We had an excellent home made (by Sandra) Lasagna that night and retired early, having had been up at 4am. We set the alarms on our phones for 5am as we wanted a dawn start to get back to Redcliffe. For some reason, one of the phones rang at 4am, though it was showing 5am, as were in the far north of South Australia and not Northern Territory. It was still dark, so carrying the battery and our belongings, Graham kindly allowed us to use his ute to get to the aircraft. After the usual DI that included replacing the battery, we set off for Birdsville at 7500'. Would you believe, we had another tail wind?! We flew directly over Poeppel Corner, where the boundaries of Queensland, South Australia and Northern Territory meet. It looked like a triangle of tracks from our height.

After refuelling at Birdsville, we had breakfast at the local bakery, short walk from the aerodrome. The local delicacy was a Camel pie, and it was delicious! On to Windorah for another hairy landing in a strong gusting cross wind. This time, the fuel bowser would not work but fortunately the local agent was passing and came to our rescue. A hairy take off followed and we were off to Charleville. Reaching 7500' took an age but worth it as a 15 knot tailwind that allowed us to sadly miss our good friend Pete in Charleville and go on to Roma. Approaching Roma, there was a large storm that needed bypassing and on landing at Roma, the local said that the storm that we had just bypassed was fast approaching. So after a quick refuel, we were on our way for the last leg to get home which we did uneventfully and well before last light, even though the tail wind had abated. Soon after landing and while hangaring the trusty Ximango, a pilot came over to ask how we went. He had not been further west than Birdsville so I quickly Airdropped Graham's phone number to him. What an excellent trip! Left on Monday, arrived back on Thursday! My youngest son wants to do it too, but in Spring and Autumn! ……..