



## BLMA Events

[brisbanelma.org/events/upcoming](http://brisbanelma.org/events/upcoming)

### FRIDAY 18 NOVEMBER

BLMA End of Year Education Event

**Time:** 6pm for 6.30pm start

**Location:** The Greek Club,  
 29 Edmondstone St, South Brisbane  
 QLD 4101, Australia

**Speakers:** Dr Tiarna Ernst "What the  
 GP needs to know about Fertility"  
 Jessica Morris, Senior Embryologist  
 "Male Fertility"

Dress is smart casual

All details will be posted shortly on  
 BLMA website



Many thanks to QML Pathology  
 couriers for distributing our  
 newsletter throughout Brisbane.



## BLMA President's Welcome

*Dr Hasthika Ellepola*  
 MBBS MD FSLCOG FRANSZCOG

Welcome to another edition of Synapse and to our new and existing, supportive members. As we head in to the final leg of 2022, our once small group, continues to grow rapidly to connect Doctors from all ends of Brisbane. Should you have any colleagues who would like to be a member, please direct them to the website or contact the Treasurer, Dr Andrew Cronin directly.

BLMA membership includes:

- ▶ Hosting bi-monthly education events, incorporating dinner, featuring speakers to inform on the latest advances in medicine;
- ▶ Ensuring high quality topics that qualify for CPD requirements;
- ▶ Organising educational workshops for Doctors in Training for upskilling clinical skills and knowledge;
- ▶ Publishing the BLMA newsletter "Synapse" which is circulated six times per year.

On 1 September 2022, we hosted yet another successful educational dinner meeting at Victoria Park,

sponsored by Perrigo. Thank you to Dr Christoph Lehner who gave a very interesting presentation, "The Whole Nine Months"

Our final educational dinner meeting is on 18 November 2022 at The Greek Club, South Brisbane. The evening is kindly sponsored by City Fertility with presentations on fertility by Dr Tiarna Ernest and Jessica Morris, Senior Embryologist. We are also excited to have AMA Queensland President, Dr Maria Boulton, who will provide an update on State and Federal AMA Advocacy.

Thank you once again to our authors and advertisers who make our newsletter the success that it is. We welcome articles and advertisements from our BLMA members. We are now accepting contributions to our next edition of Synapse which will be circulated in December, prior to Christmas. Should you wish to submit an article or advertise in this edition, please contact our newsletter coordinator, Renee O'Brien ([r.obrien@amaq.com.au](mailto:r.obrien@amaq.com.au)).



### Our new website is now live!

Keep up to date with latest news and BLMA events at your fingertips!

[brisbanelma.org](http://brisbanelma.org)

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## Issue 5 | 2022 Newsletter

**Deadline will be Friday 2 December 2022**

- ▶ Would you like to comment or suggest articles to be published?
- ▶ What would you like to see in the newsletter?

Our circulation via email, post and online reaches medical practitioners all over Brisbane!

**Contact: Renee O'Brien**

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## Are You a Member?

If you are not a member, please complete the application available on our website:

**brisbanelma.org**

**Enquiries: Dr Andrew Cronin**  
**dr.andrew.cronin@gmail.com**

Are you listed on the Member Directory on our website? Are your details correct?

**Directory form available on the website.**

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I M P O S T E R  
S Y N D R O M E

# Imposter Syndrome

By Dr Erica Gannon B Pharmacy MBBS



Dr Erica Gannon  
BLMA Member

The last few years in medicine have tested our strength and resilience beyond measure. There are many resources available about wellness, mindfulness and burnout, but many of us may be silently suffering feelings of being an imposter in our chosen field. Indeed, studies have shown that burnout has been inexplicably linked with feelings of imposter syndrome (IS). These feelings are not unique to surgeons, physicians, or any specific field of the medical profession, but rather a syndrome that doesn't discriminate against, race, religion, professional standing, qualifications or gender. What then is imposter syndrome?

Imposter Syndrome (IS) was first noted in 1978, as an inability to internalise success/meet self-imposed standards of achievement accompanied by a self-perception of 'phoniness'. Successes are often attributed to external causes eg luck, error or coincidence and the inability to accept personal/professional accomplishments can lead to low confidence, low self-esteem, anxiety, depression as well as a sense of fraudulence referred to as 'imposterism'.

This persistent doubt in one's abilities may be accompanied by a fear of being exposed as a fraud or 'fake' despite evidence to the contrary of outstanding successes both academically and physically in a chosen field/role. Whilst not formally acknowledged as a mental health diagnosis in DSM IV, it is a very real and specific form of intellectual self-doubt experienced by individuals both in and outside of the medical fields. Originally, IS was thought to apply mostly to high-achieving women but it has now been widely recognised that it does not discriminate between social standing, workforce categories, skill levels nor degree of expertise or gender.

## How to Recognise IS?

The irony of IS is that whilst suffers externally may have a proven track record of successes and accolades, they are often heightened by compliments rather than revelling in their achievements. They believe their confidence trick is working. Sufferers may believe their successes are attributed to good fortune not talent or hard

work or that someone has made a mistake and may strip them of their achievements at anytime. They fear that their peers (seniors, mentors or those they hold in high regard) will find out they are not as capable as they truly are. IS leads those impacted by it to constantly compare themselves to others with the belief that everyone else is more intelligent and superior to them. Praise for accomplishments is often dismissed by sufferers who have a tendency to diminish its importance. Often times, where a failing or incident of significance has occurred, they ruminate and focus on these events. Some of the most famous IS sufferers include Tom Hanks, Lady Gaga and even Albert Einstein.

## IS can be broken down into 5 basic types.

1. *The Perfectionist* – a held belief that unless you are 100% perfect, you could have performed better. Perfectionistic traits make the individual believe that they are inferior to their peers and therefore awaiting exposure as a fraud or an imposter.

2. **The Expert** – feelings of being an imposter arise from the premise that they don't know everything about a particular subject or field and have not yet reached a mastery level or stage. As there is more knowledge to be gained, feelings of not yet being an "expert" lead to feelings of being an imposter.
3. **The Natural Genius** – Distorted perceptions that the individual is a fraud or imposter because they are not naturally gifted/competent or intelligent.
4. **The Soloist** – Asking for/needing to seek assistance to achieve success or fill knowledge gaps makes the individual feel like an imposter as they were unable to achieve success alone. It causes them to question their skills/abilities and competence.
5. **The Superperson or Superhero** – this individual believes that they must be the hardest worker or reach highest levels of achievement and without this, they are a fraud or imposter.

The prevalence of imposter syndrome varies widely from 9% to 82% with up to 70% people experiencing a sense of imposterism at sometime during their career lifetime. It has been noted that imposterism feelings or IS can affect individuals both in a positive and a negative way. IS can have direct implications on both career progression and psychological wellness. In highly performing individuals, it may engender a sense of motivation or increased drive to succeed thus positively impacting career achievements but negative consequences of IS have been linked with emotional exhaustion in the workplace, increased work-family conflict and job dissatisfaction. Following situations where a failing is found, those with IS may be more susceptible to depression and feelings of humiliation, guilty, anxiety and

dissatisfaction. In effect, IS could be seen as a "double-edged" sword where a degree of imposterism increases a drive to succeed in some but can directly inhibit success in others.

Medicine as a profession, is particularly problematic as long-perpetuated cultural norms value confidence and perfectionism which contribute to feelings of being an imposter. Links between IS, perfectionism and high work-related stressors have also been noted in burnout studies where unfortunately positive associations with burnout and increased rates of suicide have been found. Historically medicine has fostered a hierarchical system where high expectations, both from our peers as well as society together with high rates of perfectionism put individuals at high risk for IS. It is this culture which may prevent physicians from admitting to their knowledge gaps and seeking help/assistance as this may be internalised and perceived as a sign of failure/incompetence, thus confirming fears of being an imposter. These tendencies can often lead medical practitioners with symptoms of IS to over prepare, work longer hours (to overcompensate for self-perceived failures) leading to neglect of self-care, avoidance of opportunities and realising potentials<sup>14</sup>. Such avoidances, can portend negative feedback loops of feelings of inadequacy and have impacts on diversity in leadership. IS can also negatively impact feedback conversations. A learner's growth and development may be indirectly impacted due to symptoms and feelings of IS. At a systemic level, lack of diversity in the workplace may contribute to feelings of IS. In medicine, the lack of role models reflecting gender, race/ethnicity and values may add to feelings of inadequacy and prevent those suffering with IS from stepping up into leadership roles. Diversity in these senior positions critical to provide a platform to help tackle IS at a systemic level.

## Approaches to managing IS

On an individual level, treatment strategies include cognitive behavioural therapy strategies where there is a focus on the fact thought patterns and fears are distorted eg collecting concrete evidence of achievements like attained qualifications and positive feedback as proof of distortion of thoughts and acknowledging that attaining perfection is unrealistic. Seeking help is seen as a sign of strength and not weakness. The mainstay of treatment strategies is to improve self-awareness and insight into IS. Where the symptoms of IS become overwhelming, it may necessitate formal psychotherapy together with other psychiatric treatment. Doctors Health advisory service ([drhas.org.au](http://drhas.org.au)), DRS4DRS ([drs4drs.com.au](http://drs4drs.com.au)), hand-n-hand ([handnhand.org.au](http://handnhand.org.au)) and SHIFT ([blackdoginstitute.org.au/research-projects/shfit](http://blackdoginstitute.org.au/research-projects/shfit))<sup>6</sup> provide some useful resources or starting points for supporting those with symptoms of IS. Education workshops, mentor and leadership programs at an institutional level may also be of benefit to individuals at risk or suffering from IS.

The key to change is a heightened awareness of IS. Persistent intervention and innovation across senior colleagues, administrators, mentors and junior staff will allow for better recognition of unhelpful dynamics and aid in managing them skilfully. In essence, a promotion that externally imposed frameworks have nothing to do with innate abilities, qualifications or the value of individual thoughts and concepts. IS is a complex and difficult condition but with the appropriate identification, support and treatment strategies it can be harnessed to drive positive change rather than impact negatively on our careers and self-worth.

## Answer to our question from AMA Queensland President, Dr Maria Boulton



**Dr Maria Boulton**  
*AMA Queensland President*

At our last BLMA dinner meeting our membership posed this question to AMA Queensland President, Dr Maria Boulton. Dr Boulton has kindly provided this answer to our question for Synapse.

### **With AHPRA expected to pass proposed legislation changes, how does AMA plan to mitigate resulting harm to the profession?**

Former AMA Federal President Dr Omar Khorshid and I both presented evidence at the parliamentary hearing into the proposed changes in June. We are bitterly disappointed that these amendments passed the Queensland parliament in October.

Patient safety is of paramount importance. But many of these

legislative changes will do nothing to protect the public. Regulatory authorities already have powers in place to protect the public, eg stop a health practitioner from practising if they are concerned.

The only impact will be to make practising more difficult for doctors, nurses and other healthcare workers and increase their already high risk of suicide.

Naming and shaming healthcare workers before any allegation is proven goes against natural justice. Once an allegation is made public, it lives forever on the internet.

These are bad law changes that should be immediately reversed and we are continuing to lobby the

Queensland government for change, and for an understanding of what would trigger the naming and shaming of an individual practitioner.

AMA Queensland is aware of the ongoing concerns of doctors and continues to put pressure on the Federal and State Governments in relation to its implementation now it has passed.

I am very much looking forward to joining you at the BLMA meeting on Friday 18 November at The Greek Club.



**Dr Andrew Frazer**  
*BLMA Committee Member*

## Meet the BLMA Committee

### **Committee Member – Dr Andrew Frazer**

Originally hailing from North Queensland, Andrew has had a varied career working regionally in Toowoomba and Cairns, before working for the Australian Medical Council in Canberra. Since returning to Queensland he has had roles at the Wesley Hospital, the Queensland COVID Response Team and is currently working at Metro North Hospital and Health Service. This current role includes working in the Virtual Ward and in Emergency Management.

He is currently undertaking Registrar training in Medical Administration and has Science, Public Health and Healthcare Leadership qualifications.

Andrew has a keen interest in medical education and junior doctor training.

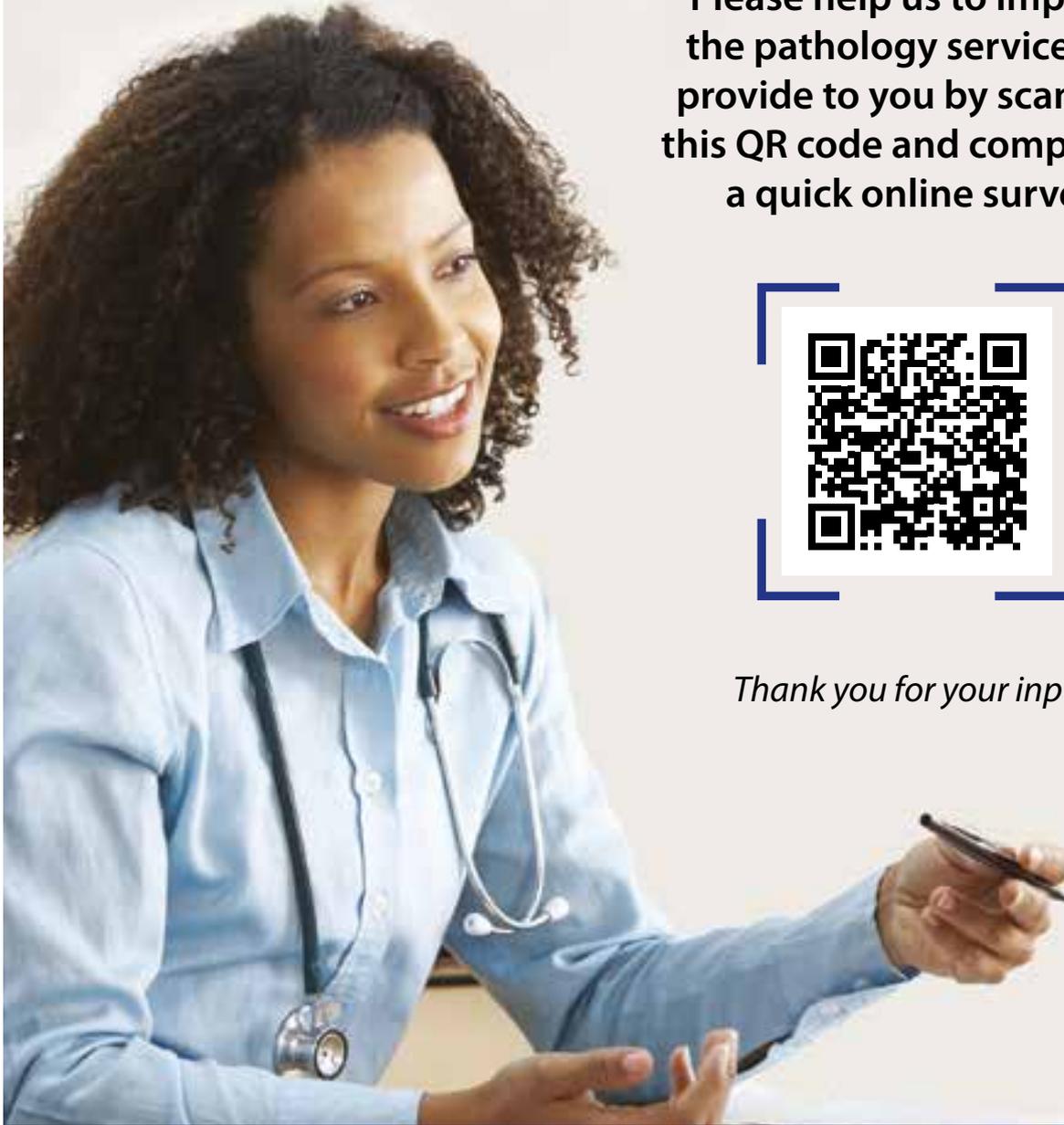
Andrew joined the BLMA in 2021 and joined the management committee in 2022 as the Doctor in Training representative.

# We value your feedback

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*Thank you for your input.*



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# Management of Dyslipidaemia: A Recap and Novel Therapies

By Dr Douglas Roche MD B.Med.Sci.



Dr Douglas Roche  
BLMA Member

Dyslipidaemia is possibly the most easily modifiable risk factor for cardiovascular disease, which remains the leading cause of death in Australia. There is increasing awareness of the role of lipid disorders in the development of non-vascular diseases such as non-alcoholic fatty liver disease, chronic kidney disease and pancreatitis. Aggressive lipid control is fundamental to reduce atherosclerotic burden, and advances in lipid lowering therapy have made such targets achievable for the vast majority of the population. While general practitioners are the mainstay of risk factor management at a population level, it's important for most other

specialities to have a general understanding of lipid management in order to catch those patients who might otherwise slip through the cracks.

Unfortunately, there is still no national guideline on treatment of dyslipidaemia. While the topic is addressed in the Heart Foundation Guidelines on Absolute Cardiovascular Disease Risk, and the RACGP Red Book, these have not been updated since 2012 and 2016 respectively. Each of these resources focuses on an absolute cardiovascular risk assessment approach using the Framingham Risk Equation, and recommend checking a lipid profile as part

of assessing absolute risk for all patients above 45, and Aboriginal and Torres Strait Islander people above 35. Initiation of pharmacotherapy is recommended both for those with abnormal results, and those who fall into the high risk category (greater than 15% risk of MI or CVA in the next 5 years). Lipid targets in these guidelines are risk-agnostic – please see Table 1 for a comparison of recommendations.

In contrast, the European Society of Cardiology (ESC) guidelines from 2019 focus primarily on LDL-cholesterol, with targets based on the SCORE risk assessment tool (validated for European countries only, now succeeded by SCORE2).

**Table 1: Comparison of Cholesterol Targets**

	RACGP/Heart Foundation Guidelines	ESC Very-high risk (>10%)	ESC High-risk (5-10%)	ESC Moderate risk (1-5%)	ESC Low risk (<1%)
<b>Total cholesterol</b>	<4.0mmol/L				
<b>LDL-C</b>	<2.0mmol/L	>50% reduction from baseline and LDL <1.4mmol/L	<1.8mmol/L	<2.6mmol/L	<3mmol/L
<b>HDL-C</b>	≥ 1mmol/L				

Secondary prevention is sometimes overlooked. Naturally, a lipid profile should be performed for all patients with acute coronary syndrome, stroke and TIA. These patients should always be considered as 'very-high-risk', which the European Society of Cardiology considers commensurate with a risk of >10% for fatal cardiovascular disease over 10 years. They should be commenced on high density statin therapy (20-40mg/day of rosuvastatin or 40-80mg/day of atorvastatin), targeting LDL of <1.4%. Most patients tolerate high-intensity statin therapy, which is preferred to starting at moderate-intensity and uptitrating. Ezetimibe should be added if the patient is not meeting this target, or, if the patient does not tolerate high-intensity statin therapy, added to moderate-intensity statin therapy.

Another group that warrants consideration is those with inherited hypercholesterolaemias. Familial Hypercholesterolaemia is caused by a major genetic defect in the LDL clearance pathway, most commonly by variants in the LDLR, APOB, and/or PCSK9 genes. It is an autosomal co-dominant disorder, the severity of which varies enormously between homozygous and heterozygous individuals. The Dutch Criteria (available on MDCalc) are most commonly used for diagnosis; these are assisted by genetic testing which is MBS subsidised when ordered by a specialist physician for those who meet criteria. Heterozygous familial hypercholesterolaemia (HeFH) is very common, with a prevalence of approximately 1:250 in the community. These patients may have no visible signs of disease, or may have premature coronary artery or peripheral vascular disease. In contrast, homozygous familial hypercholesterolaemia is much rarer, with a prevalence of 1:160000 to 1:1000000. These patients are generally diagnosed before 30 years

of age, as most patients will not live past 30 years of age without treatment.

In the last decade, proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors have become an important tool in lowering LDL-cholesterol for those who either do not achieve targets on statins or are intolerant of statins. PCSK9 is a protein primarily expressed in the liver. The LDL receptor facilitates uptake of LDL-C into the hepatocyte, at which point the LDL-C is degraded in endosomes, thereby lowering plasma LDL-C levels. PCSK9 binds to the extracellular part of the LDL receptor. After the LDL receptor is trafficked into the cell and then into the lysosome, it can either be degraded or recycled. PCSK9 makes the LDL receptor susceptible to enzymatic degradation by preventing it from forming a closed conformation. As a result, it cannot be recycled to the cell surface, reducing the overall expression of LDL receptors and increasing plasma LDL-C. By inhibiting PCSK9, LDL receptors are not 'tagged' for destruction and can therefore be recycled to the cell surface and reduce plasma LDL-C.

PCSK9 inhibitors have shown remarkable results when added to statin therapy. The FOURIER trial showed that inhibition of PCSK9 with evolocumab, as compared with placebo, lowered LDL-C by 59%, from a median baseline value of 2.4mmol/L to 0.78mmol/L. This was associated with a reduced risk of adverse cardiovascular outcomes (cardiovascular death, MI, stroke, unstable angina, or coronary revascularisation) with a hazard ratio of .85 (95% CI 0.79 to 0.92). There are two PCSK9 inhibitors currently available in Australia – evolocumab (Repatha) and alirocumab (Praluent). These are administered by subcutaneous injection either fortnightly or monthly.

Due to their expense (approximately \$500/month), the PBS criteria for PCSK9 inhibitors are fairly narrow. Treatment must be initiated by a specialist physician. PBS- subsidised indications include a diagnosis of familial homozygous hypercholesterolaemia or familial heterozygous hypercholesterolaemia. For those with non-familial hypercholesterolaemia, treatment is limited to those who have symptomatic atherosclerotic cardiovascular disease with LDL >2.6mmol/L, have received a maximum-dose high-intensity statin and ezetimibe for at least 12 weeks or have adverse events with a statin, and have one other risk factor. The high cost of PCSK9 inhibitors limits their utility at a population level.

Future directions include an increased role for lipoprotein a (Lp(a)), a marker with proven association with cardiovascular risk but with no current specific effective treatment. ESC guidelines recommend testing for Lp(a) (not currently MBS subsidised) once in each person's lifetime to identify those with extremely elevated levels (which are generally hereditary) who would benefit from intensive risk factor management.

Overall, however, the primacy of lowering LDL cholesterol remains unchallenged. There is no unsafe lower limit of LDL-C. Due to the benefits of treatment, all patient-facing doctors should give consideration to opportunistically finding those patients at risk of dyslipidaemia.

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\* For more details please visit our website  
[qld.ama.com.au/events/annual-conference-Lisbon](http://qld.ama.com.au/events/annual-conference-Lisbon)



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# Biologic agents: Benefits and risks for patients with inflammatory arthritis

By Dr Peter Landsberg, Rheumatologist,  
ArthritisCARE Rheumatology,  
[www.arthritiscare.com.au](http://www.arthritiscare.com.au)



Dr Peter Landsberg  
BLMA Member

Disease-modifying antirheumatic drugs (DMARDs) have been used for many years in management of rheumatoid disease, psoriatic arthritis and the inflammatory arthropathies such as ankylosing spondylitis. These conventional synthetic DMARDs including methotrexate, hydroxychloroquine, salazopyrin, and leflunomide have been effective in achieving remission for many patients.

Biological therapies are now available to Rheumatologists for use in place of, or in combination with, the synthetic DMARDs. Biologic drugs are often monoclonal antibodies which target specific proteins to reduce the intensity of the inflammation and sometimes turn off the disease.

Appearing in the early 2000's the original biological agents were the TNF (tumour necrosis factor) blockers, namely etanercept and adalimumab. Following these, other groups of biologics were developed including T-cell and B-cell inhibitors and Interleukin inhibitors, each targeting a specific cell or cytokine to reduce inflammation and joint damage.

The newest drugs available are the very potent JAK inhibitors which are taken orally, as opposed to the delivery by injection or infusion required for the other biologics. The Janus kinase (JAK) enzymes are intracellular enzymes that regulate inflammation within activated lymphocytes. By blocking different types of JAK enzymes, autoimmune disease can be turned off.

The biological drugs aren't "cures". But the remission rate achieved is pleasingly somewhere between 60-70%.

## ***When do Rheumatologists consider biologics?***

The main reason to move to considering biologics is when the conventional DMARDs are failing to control disease activity. Many patients will trial two or more agents before experiencing disease remission with tolerable side effects.

Because these medications cost upwards of \$20,000 per year and are heavily subsidised by the Pharmaceutical Benefits Scheme, Rheumatologists are required to adhere to strict protocols when applying for approval of each and every prescription for biologic agents. This includes documentation of evidence of six months of failure of conventional therapies. In addition, after a four-month trial of a biologic agent, there has to be at least a 20% improvement in the inflammatory markers (ESR and CRP) and the patient's joint count for Medicare to continue to approve and fund supply.

## ***Side-effect profile and management guidelines***

The issue with all biological agents is that they are more potently immunosuppressive than methotrexate and leflunomide and therefore have a much higher rate

of incidental infection. Bacterial infections in particular, like pneumonia, cellulitis, diverticulitis occur more commonly in patients on biological drugs.

There are a host of rarer immunogenic side effects like development of autoimmune hepatitis, flares of inflammatory bowel disease, and paradoxically even psoriasis. In rare cases TNF Blockers have been known to trigger demyelination and multiple sclerosis in patients who are prone to develop the disease.

We always advise our patients to stop taking their biologic agent and see their GP urgently if they feel like they have any infection. Most biologics can be stopped easily for a week or two without a flare up and we recommend urgent use of antibiotics for anything significant like an acute diverticulitis or bronchitis etc.

Other areas of caution include avoidance of live vaccines for patients on biologics and pausing the biologics for any surgery and post-surgical period to minimise risk of infection.

If your patients are on biological drugs and you have concerns, please contact their Rheumatologist to discuss any issues.

# ADHD in Children & Adolescents... making a difference!

By Dr Michael Williams MBBS (Hons) FRACP MMedSci



Dr Michael Williams

ADHD is common with a worldwide prevalence of 7%. It impacts the child, their family, and schools, and it is something where we, as Doctors, can make a difference. ADHD is more commonly identified in general practice, with confirmation and management initiated by a paediatrician, and followed up by the child's GP.

The core feature of ADHD is inattention with easy distractibility, usually with overactivity, fidgetiness and impulsivity. These symptoms are seen in certain situations with some tasks, especially at school, but not at home e.g., doing Lego, and are usually apparent after the child commences school. For the child it means difficulty fitting in at school and failing to learn to their potential which can have negative impacts on the child's self-esteem ("I'm dumb – I can't do that"). At home, the child's poor organisation and frustrated behaviours can be testing for parents.

ADHD is often associated with other difficulties such as:

- ▶ Difficulty in going to sleep, sometimes taking hours

- ▶ Autism Spectrum Disorder
- ▶ Oppositional Defiant Disorder – but could this also be features of ASD?
- ▶ Tics
- ▶ Learning difficulties e.g., dyslexia

Other causes of inattention and difficult behaviours need to be excluded, especially family dysfunction, domestic violence and chronic medical conditions that can cause sleep disruption e.g. obstructive sleep apnoea and eczema. Hearing and vision should also be checked.

ADHD is generally familial, but not always. Prematurity or low birth weight and severe social factors, especially deprivation of parental attachment, have been associated with ADHD.

Difficulties arising from ADHD are usually seen early in childhood but often persist into adolescence, and for some, into adulthood. Recognising and managing the difficulties and helping parents and teachers to understand and support the child may help prevent long term negative impacts.

The aim is to help the child to learn to their potential, maintain their self-esteem with a positive relationship with their parents and teachers, and to minimise the risk of drug abuse, injury and poor mental health that can occur with ADHD.

A child who presents with learning or behavioural difficulties should be assessed for ADHD. The SNAP IV or Vanderbilt forms are good investigation tools, both freely available and easy to interpret, and usually completed by parents and teachers. If the history and the feedback from the form suggest ADHD, then paediatrician review is appropriate to confirm diagnosis, look for associated conditions, discuss issues with parents and recommend a management plan. When referring, include the teacher and parent SNAP IV, Vanderbilt or similar ADHD rating scale, along with weight, height and BP. If the child is at a rural site, paediatric consultation by telehealth, often with the parent and teacher at the school, is effective and appreciated by the families.

Following the diagnosis of ADHD, stimulant medication will usually be trialled. This may be either **methylphenidate** or **dexamphetamine**, taken daily or just on school days. The aim is to help the child to engage with their schooling and learning and interact better at home and in the community. A paediatrician is required to initiate stimulant medication for those aged under 18 years. For older children or adolescents, I would usually commence with **lisdexamphetamine** as it is long-acting (up to 12hours); and so only needs morning dosing before school and can be prescribed on the PBS without the need of an initial short-acting form. The stimulant medications are generally well tolerated, with appetite suppression at school the most common adverse effect. Other medications may be used: **clonidine**, usually for a calming effect in the

evening and to help with sleep initiation, **guanfacine** to reduce aggressive behaviours during the day, and **atomoxetine** if the stimulants appear to be not suitable. **Melatonin** can help with getting to sleep if other bedtime routines fail.

Other measures to help the child with ADHD include classroom strategies, behaviour management plans, ensuring outdoor activity each day, and limiting screen time especially in the evenings. Follow up is best with the GP at least 6 monthly to monitor progress, growth, BP and parenting concerns, and provide scripts. The paediatrician can review the child if there are queries or difficulties in the interim.

Supporting the child with ADHD and their parents should be seen as a preventative investment in the child's future.

Some ADHD Resources for parents:

Kids Health Information: Attention deficit hyperactivity disorder (ADHD) ([rch.org.au](http://rch.org.au))

<https://raisingchildren.net.au/teens/behaviour/adhd/adhd>

Further reading:

Pharmacologic Treatment of Attention Deficit-Hyperactivity Disorder. N Engl J Med 2020;383:1050-6.



**QUEENSLAND**  
PAEDIATRIC TELEHEALTH SERVICE

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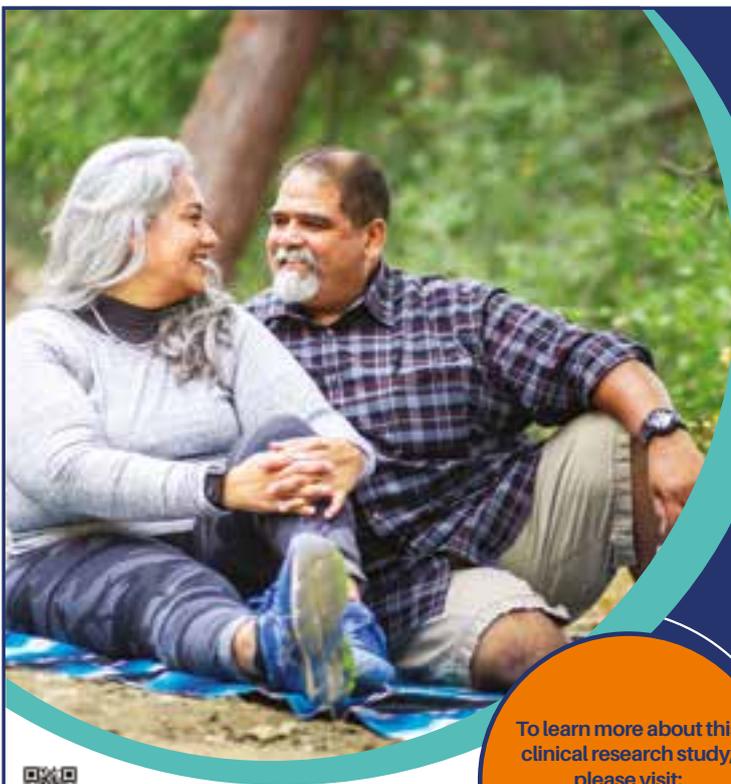
# Urinary tract infections (UTI)

*Dr Johanna Mayer-Coverdale FRCPA FRACP,  
Clinical Microbiologist & Infectious Diseases Physician*

Urinary tract infections (UTI) are one of the leading causes of seeking healthcare and being prescribed antibiotics in Australia. Associated complications, including blood stream infections (BSI), result in more than 70,000 excess hospitalisations annually<sup>1</sup>. Extraintestinal pathogenic *E. coli* (ExPEC) accounts for more than 75% of community acquired UTIs, it is also the second leading cause of BSI in Australia. Invasive ExPEC is associated with excess morbidity and mortality, particularly in people over 60<sup>2</sup>. *E. coli* has been listed as one of the top 5 critical antimicrobial

resistance (AMR) pathogens. These infections are now becoming increasingly resistant to all available treatment options. In the setting of a global AMR crises, alternative methods of combating infection are needed. Vaccination plays a pivotal role in prevention of infectious diseases and therefore is a key tool in the armamentarium to fight AMR<sup>3</sup>. A safe and effective ExPEC vaccine will prevent excess hospitalisations, decrease unnecessary antibiotic prescribing and most importantly protect vulnerable older people from a potentially life-threatening infection.

1. Australian Commission on Safety and Quality in Health Care. Australia Atlas of Healthcare Variation 2017: 1.4 Kidney and urinary tract infections, 2017.
2. Bonten M, Johnson JR, van den Biggelaar AHJ, et al. Epidemiology of Escherichia coli Bacteremia: A Systematic Literature Review. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America* 2021; **72**(7): 1211-9.
3. Jansen KU, Anderson AS. The role of vaccines in fighting antimicrobial resistance (AMR). *Hum Vaccin Immunother* 2018; **14**(9): 2142-9.



The image depicted contains models and is being used for illustrative purposes only.  
Janssen Research & Development, LLC  
1WAG52416BAC3001-ENG13  
Version 2.0, 19MAY2021



To learn more about this clinical research study, please visit:  
[EmbraceVaccineStudy.com](https://EmbraceVaccineStudy.com)

**E.mbrace**  
STUDY

## Now enrolling adults 60 years of age or older who may be at risk for developing a bloodstream infection caused by *E. coli*

*E. coli* is the most common cause of urinary tract infections and invasive bacterial diseases in older adults. Janssen Research & Development is conducting a clinical research study to evaluate an investigational vaccine in the prevention of Invasive *E. coli* Disease.

Please consider this clinical research study opportunity for potential participants who:

- Are 60 years of age or older and medically stable
- Have had a urinary tract infection (UTI) in the past 2 years
- Feel comfortable, or have a caregiver who is comfortable, using an application on a smartphone

For more information, please speak with:

STUDY COORDINATOR: Bernadette Rickards  
(07) 3346 5060 or email: [b.rickards@uq.edu.au](mailto:b.rickards@uq.edu.au)

INVESTIGATOR: Dr Johanna Mayer-Coverdale  
email: [j.mayercoverdale@uq.edu.au](mailto:j.mayercoverdale@uq.edu.au)



Dr David Ramsay is an Orthopaedic Surgeon at the Indillie Clinic, Redlands and operating from Greenslopes and Mater Redlands Private Hospitals.

His specialty interest is in conditions of the hip and knee, especially managing arthritis. This includes a full spectrum of care from simply educating and coordinating non-surgical treatments, right through arthroscopic surgery

and joint replacements and revisions.

With subspecialist fellowships involving a year spent in Tasmania doing anterior hip replacements and sports knee and hip surgery, and a year in Edinburgh, Scotland doing hip and knee replacements he offers world class care, locally.

In the area of knee replacement he is using the latest Zimmer-Biomet ROSA robotic assisted surgical technologies, and works closely with Zimmer to offer patient support and education through the MyMobility mobile App as patients travel their joint replacement journey.

*Indillie*



*Clinic*



Dr Simone Ramsay is a General Surgeon with Colorectal fellowship training.

She manages a range of general surgical conditions such as hernias and gall bladder issues.

Her particular interest is in the management of colorectal complaints including rectal bleeding, haemorrhoids,

perianal abscesses, fistulas, faecal incontinence and bowel cancers. She is trained and credentialed in Colonoscopy, which she performs no-gap.

Dr Ramsay conducts regular clinics performing excision of skin and subcutaneous lesions in our fully equipped procedure room, under local anaesthetic for suitable patients.

For those patients who need or would prefer hospital treatment or general anaesthesia, Dr Ramsay can treat them at Mater Private Hospital Redlands.

To learn more about Dr David Ramsay and Dr Simone Ramsay, visit our website at [www.indillieclinic.com.au](http://www.indillieclinic.com.au), or contact Lee Bertram, Practice manager on 07 31637395



## AMA Queensland update [qld.ama.com.au](http://qld.ama.com.au)



Dr Maria Boulton  
AMA Queensland President



Dr Brett Dale  
AMA Queensland CEO



## PRESIDENT AND CEO UPDATE

On 1 October, the urinary tract infection (UTI) prescribing pilot became a permanent fixture of the Queensland health system. On 31 October, the declared public health emergency for COVID-19 expired at midnight and mandatory mask wearing became a thing of the past.

In between, changes to the National Law allowing Ahpra to name and shame doctors under investigation passed the Queensland parliament, the government formally announced its plans for the North Queensland pharmacy prescribing experiment, doctors came under unfounded attacks over alleged Medicare fraud, and the federal budget stripped \$2.4 billion from the nation's public hospitals.

It's been a busy month but AMA Queensland will continue to work tirelessly for our members and the community for the best health outcomes for all.

### Federal budget

The Albanese Government's first budget delivered little to address the issues affecting Queensland – ambulance ramping, bed access block, elective surgery wait lists and the woeful Medicare rebates for patients to access medical services.

Even worse, the budget cuts \$2.4 billion nationally over the next four years from public hospital funding based on state forecasts of fewer hospital services to be delivered in that time.

States have cut their forecasts because they don't have the staff or the resources to deliver these services. It makes no sense to exacerbate the problem by cutting even more funding and perpetuating a vicious cycle of reduced services.

The federal government will also no longer go 50-50 with the states on COVID-related public hospital costs from the end of this year.

Our hospitals were already under pressure before COVID, but almost three years of pandemic has stretched our healthcare workforce to breaking point.

This pandemic is not over.

We had hoped that having the same party in power federally and in the state would make it easier for both levels of government to resolve these funding issues. We were wrong.

We will continue to campaign fiercely to increase funding for our hospitals, to reform Medicare and to support our rural and regional workforce.

Read more about our federal budget response at [qld.ama.com.au/news/FedBudget](http://qld.ama.com.au/news/FedBudget)

## North Queensland pharmacy pilot

We remain opposed to the state government's decision to push ahead with its dangerous plan to allow retail pharmacists in North Queensland to diagnose and prescribe for a range of serious medical conditions.

The government has confirmed the North Queensland pharmacy trial will go ahead. However, our advocacy successfully delayed its commencement by more than 12 months and reduced the number of conditions from the original 23 to 17.

We have not given up. This dangerous experiment shows a blatant disregard for patient safety and will do nothing to reduce the pressure on general practice, hospitals or ambulances.

This trial goes against the independent, unbiased, evidence-based advice from the Therapeutic Goods Administration (TGA) about who can prescribe and access medication, and research into patient safety.

We have met with the Office of the Health Ombudsman (OHO) to raise our concerns about the lack of reporting mechanisms for patients who were harmed by the urinary tract infection (UTI) prescribing pilot that was the basis for the North Queensland trial.

The OHO shares our concerns about the lack of communication with doctors about the UTI and North Queensland trials and has committed to providing information and clear reporting pathways for doctors and patients.

Read more about our response to the trial announcement at [qld.ama.com.au/news/Pharmacy-trial-danger](https://qld.ama.com.au/news/Pharmacy-trial-danger).

## Medicare

We were disappointed to see three respected media outlets – the ABC, *The Sydney Morning Herald* and *The Age* – making unverified claims about alleged Medicare fraud.

Members are rightly upset by this. GPs have been on the frontline of the COVID response for almost three years – treating patients, delivering vaccines and keeping people out of hospital. They're fatigued and burnt out.

We know that every cent of health funding is precious and if anyone is rorting the system, they should be identified and penalised.

However, we have seen no evidence to back the claims of \$8 billion a year in fraud.

Medicare is no longer fit for purpose. The patient rebates go nowhere near the cost of providing quality health care and it is time to overhaul the entire system. That's why we've joined a federal taskforce to reform Medicare.

Read Dr Maria Boulton's interview with ABC Sunshine Coast at [qld.ama.com.au/news/MBSclaims](https://qld.ama.com.au/news/MBSclaims)

## National Law

AMA Queensland vigorously opposed the changes to the National Law that passed Queensland parliament in October.

Dr Maria Boulton and then AMA President Dr Omar Khorshid appeared before the parliamentary inquiry in June to query why the changes were necessary.

Of all the amendments, the ability of Ahpra or the medical board to be able to issue a public warning before a tribunal has completed its actions is the most troubling.

We do not understand why the harsh steps are necessary when Ahpra and the medical board already have powers to protect the public if a practitioner poses a serious risk.

We have not been given any evidence of how this additional power will assist in protecting the public. We can only conclude that this lack of evidence is because there is none, and we are absolutely of the view that issuing a public warning implies guilt and is likely to ruin a practitioner's reputation, possibly ruin their lives.

Even if such statements are withdrawn down the track, it is a completely non-retractable step and will cause irreparable harm to the health and wellbeing of practitioners who may have done nothing wrong.

You can read more about the AMA's advocacy at [ama.com.au/ama-rounds/14-october-2022/articles/national-law-changes-go-through-queensland-parliament](https://ama.com.au/ama-rounds/14-october-2022/articles/national-law-changes-go-through-queensland-parliament)

## Regional workforce

In October we travelled to Rockhampton and Gladstone to hear firsthand from doctors and patients about the strained medical system in Central Queensland.

The Gladstone Hospital maternity unit has been on bypass for months, meaning that women in labour have to travel to Rockhampton or further to give birth.

The phased reopening of the maternity unit, beginning with elective caesareans from mid-October, is welcome but does not resolve the ongoing issues facing patients, doctors, nurses and midwives in the region.

The patient stories were shocking – a family with a woman in labour who drove from Biloela to Gladstone, only to be told to keep driving to Rockhampton; a new mother who was given the option of a 90-minute ambulance trip without her baby to wait in the Rockhampton ED to be stitched, or wait until 7am when the suturing-qualified midwife came on shift.

The staff stories were just as disturbing – no junior doctors, consultants doing the work of two to three people while also being on call, working 30-hour shifts with a four-hour break, no locums, no respite. Our international medical graduates (IMGs) feel abandoned and Australian-trained doctors warn they will walk away.

We warned back in 2018 when Queensland Health purchased the Mater Private Hospital in Gladstone that it would lead to the end of private obstetrics in the region. Sadly, we were right.

We are facing a global shortfall of 15 million healthcare workers by 2030.

It is clear we need real action in Queensland. We need a real investment in healthcare services and staff. We need to grow our own medical workforce, and we need to treat our international medical graduates better.

Read more at [qld.ama.com.au/news/gladstone-maternity-services](http://qld.ama.com.au/news/gladstone-maternity-services) and [qld.ama.com.au/news/CQMaternity](http://qld.ama.com.au/news/CQMaternity).

## Voluntary patient enrolment

AMA Queensland and our state and national counterparts have been actively engaging with governments at all levels to drive whole-of-healthcare reform for primary care, particularly Medicare rebate reform to ensure longer, more complex consultations attract rebates that reflect the extra resourcing involved.

We believe this should always be delivered through a fee-for-service Medicare model.

The current Medicare funding model is not fit for purpose. Appropriately indexing the rebates is absolutely essential for general practice. GPs deliver 180 million services each year. Increasing each of those by \$10 will cost \$1.8 billion.

Implementing voluntary patient enrolment (VPE) is among the reforms recommended in the Australian Government's *Primary Health Care 10-Year Plan 2022-2032*.

VPE is not capitation, in which the healthcare provider receives a set payment for every patient attributed

to them, regardless of the number of times the patient seeks care. The AMA does not and will not support a move to capitation.

Voluntary patient enrolment with a GP or practice establishes a formal relationship with the patient, providing a basis for shared goals and outcomes. This in turn provides a framework for funding reform that rewards continuity of care. For example, chronic disease management plans and health assessments would be linked to these relationships.

This funding is in addition to, not instead of, Medicare fee for service.

The AMA supports VPE, provided it is designed appropriately, strengthens the position of general practice in our health system, and provides a basis for government to deliver extra investment into general practice.

We will oppose any initiatives that do not increase funding into general practice.

Read our member update at [qld.ama.com.au/news/VPEfacts](http://qld.ama.com.au/news/VPEfacts)



AMA QUEENSLAND

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## Ramping

Ambulance ramping continues to be a concern, with Queensland recording the worst statistics in the nation according to figures released in early October.

The figures, from the height of the COVID pandemic in July, showed 73 per cent of patients at Redland Hospital and 66 per cent at Logan Hospital were ramped for more than 30 minutes.

At the time, we had hundreds of COVID patients in hospital and thousands of staff furloughed either with COVID or as close contacts

However, we have seen little sign of improvement and will continue to pursue our Ramping Roundtable's five-point action plan to reduce stress on all areas of our hospitals, from emergency departments to other wards and the discharge process.

Read Dr Maria Boulton's interview on *Sunrise* at [qld.ama.com.au/news/Sunrise-ramping](http://qld.ama.com.au/news/Sunrise-ramping)

## Women in Medicine

It was a pleasure to attend our sold-out *Women in Medicine Breakfast* with 240 keen attendees, including babies.

Read Dr Boulton's speech at [qld.ama.com.au/news/WIMspeech](http://qld.ama.com.au/news/WIMspeech) and check out the photo gallery on our Facebook page.



DRS RASHMI GURURAJAN, ASHLEA WHITE AND ABIGAIL LANE WITH BABY ELI



OUR WOMEN IN MEDICINE PANEL: DRS NATASHA ABEYSEKERA AND FIONA RACITI, PROF BEVERLEY ROWBOTHAM AO AND DR ELEANOR CHEW OAM.



DR MARIA BOULTON



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# MEDIA STATEMENT



22 September 2022

## A focus on the future – GP workforce in Queensland

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The Queensland Primary Health Networks (PHNs) will play a key role in the distribution of the General Practitioner (GP) trainee workforce after being awarded a grant through the Australian Government's Health Workforce Program.

Working with key stakeholder groups across Queensland, the consortium of the seven Queensland PHNs will provide analysis and advice on the priority locations for GP training placements to meet current and future GP workforce needs, through the Australian General Practice Training (AGPT) Program GP Workforce Planning and Prioritisation grant. This work will make a vital contribution to the future of GP training that will be delivered by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) from February 2023.

"The PHNs' advice will inform the distribution of the GP trainee workforce across our diverse communities across Queensland and support the transition to College-led GP training," Brisbane North PHN CEO Libby Dunstan said. "It will also enable greater visibility of GP training opportunities to support GP trainees to undertake their training in a single region and acquire the skills to meet that community's health needs. The distribution approach under the College-led model deliberately provides a level of flexibility in how registrar distribution is achieved to ensure that placement decisions support a safe and positive registrar experience".

The AGPT Program provides full-time, on-the-job training for doctors who want to specialise in general practice and/or rural and remote medicine who can then work as GPs anywhere in Australia. The three to four-year training program offers 1,500 training places each year under a competitive merit-based process. It is delivered by ACRRM and the RACGP.

PHNs will use their well-established relationships with local general practices and stakeholders to map the existing and future GP and trainee workforce in each GP catchment area. A key focus will be for each PHN to map community need against workforce and GP training requirements.

"We will collect data on the current GP workforce, vacancy data, training practice accreditation, capacity and any retirement and succession plans. This information will be used to provide advice to the Colleges on prioritising AGPT training placements to meet current and future GP workforce needs to match the needs of communities," said Ms Dunstan.

"PHNs are well placed to provide this advice. We've supported our primary care workforce and established highly effective stakeholder relationships across the health system since 2015. We have deeply embedded working relationships with general practices and have also conducted comprehensive Health Needs Assessments to determine the health and service needs of the population and health care system within our catchment regions," said Ms Dunstan.

### ENDS ###

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