

# 屋崙中華醫學會通訊

acma  
news

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AUCKLAND CHINESE MEDICAL ASSOCIATION  
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## president's message

### Greetings

The end of the year is nearing at lightning speed as usual and seemingly we can barely take a breath. Fortunately in New Zealand we don't quite have the work ethos of some of our Asian counterparts who appear to not breathe at all! I was fortunate enough to attend the 12th Asian and Australasian Society of Anaesthetists conference in Singapore. I was quite taken at the hours many of my colleagues accumulated each week working a far cry from my so called busy schedule. Certainly I did wonder how they managed to keep the quality up despite the continual sleep deprivation that many suffered. (Mind you I caught up on mine at the conference). Listening to all the regional differences in various areas of practice made you realize that, compared to many of the second and third world countries we could certainly count our lucky stars. Obviously once in Singapore you had to do all the usual stuff like Singapore slings at the Raffles Hotel followed by endless retail therapy (because it was too hot and humid outside). This was followed by endless eating, in fact the trip ended up as a bit of an eating safari, with the variety and quality too good to turn down.

Looks like we have had another successful year at ACMA. With slightly more CME meetings this year as well as the two yearly conference. All well supported by the members. It is fantastic to see the association remain strong. YACMA have tried to do some new things this year including some benevolent objectives which I think have born fruit. Well done YACMA.

Since this is the last newsletter of the year I would like time to thank all those involved in the ACMA and YACMA committees. Time given pro bono, keeping the association going forward strongly. The ACMA is lucky to have such a good group whose guardianship keeps the ACMA going from year to year.

*Dr Colin King*



**THE MEDICAL PROFESSION AS  
GATEKEEPERS OF THE ACC SCHEME**  
- Phil Murch, ACC Auckland

ACC formed in 1968 under Sir Owen Woodhouse. It was rolled out in 1972. Principles were: 1. No fault injury cover 2. Treatment costs 3. Rehabilitation 4. Prevention. It effectively shut out the legal system in relationship to compensation for difficult injuries / accidents.

The ACC scheme provides 24 hour, no-fault personal injury cover at work, at home, on the road and at play, available for all New Zealand residents including visitors.

ACC processes 1.7 million claims and 6 million transactions. It collects over \$2.7 billion in premiums and spends over \$2 billion in scheme costs. In any week day, 3 people will die from an accident, 4000 will need medical treatment and ACC will pay out \$5 million.

Only 5% of these injuries are complex or serious.

Goal for the injured is rehabilitation incorporating other providers including surgical repair, investigative X-rays, MRI, CTs, and US. ACC cover entitlements include emergency transport, medical treatment, ancillary services including transport and accommodation, earnings related compensation, social / vocational rehabilitation, and lump sum compensation for permanent impairment. Treatment and rehabilitation can be provided by the initial medical provider, or through referral to an acupuncturist, physiotherapist, chiropractor, or specialist.

80% of gross income over the past 12 months is paid while recovering. If the patient was unemployed, they will receive very little in income.

Social rehabilitation, such as home help, is covered. Vocational assessment, including retraining and workplace assessment is also covered.

Forms: ACC45 needs to be completed by both the medical provider and the patient. This is used to register a claim with the ACC and is also used to certify time off work. ACC18 is a further medical

certificate used to certify: (FUF) – Fully Unfit, and (FFSW) Fit for Selected Work.

If the patient is unable to return to their previous role, ask if they are suitable for selected work. This will trigger a vocational rehab officer to do a worksite assessment to see how your patient may return to work safely. When a GP certifies a claimant as being fully unfit, ACC is unable to commence vocational rehab. This may cause a delay in a claimant recovery and return to work. Often certified because the GP is unaware of a patients work task or job. Check “can you work with this injury? / Are there any light duties? / What do you do at work? / Are there alternative duties?”

Check the Department of Labour website or the ACC website for more information.

Certifying FFSW does not suspend claimants entitlement to Earnings Related Compensation. ACC will not return a person back to work without determining whether the employer has alternate duties in line with the restriction on the ACC18.

ACC will request a worksite assessment from a contracted provider. The provider will meet with the employer and the claimant at the workplace to determine what tasks are involved in the preinjury occupation. The assessment will also determined what alternate tasks the employer is able to offer in line with the injury restriction, then a copy of the assessment report is given to the claimant, employer and GP, so that the GP can determine whether the alternate tasks are able to be managed within the restrictions.

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**OPIUM USE IN PALLIATIVE CARE PATIENTS**

- Prof Rod MacLeod, Waitemata DHB

Regular analgesics are used in chronic pain. We need to look at: psychological, physical, social and spiritual pain, especially with end of life care. WHO analgesic ladder shows: Step 1) non-opioid use e.g. paracetamol Step 2) Weak opioid and non-opioid such as codeine and tramadol Step 3) Strong opioids + non-opioid e.g. morphine and oxycodone. Adjuvant therapy is needed at all stages e.g. tricyclics, etc.

Titrate up sevredol and give it regularly. Increase dose by 30% each day until patient is comfortable. e.g. 20mg morphine every 4 hours = 120mg a day. Then give 50% every 12 hours use a diary for break through pain and total dose can be recalculated. A subcutaneous syringe driver uses 50% of total morphine dose daily. Use syringes in

very sick and patients who are unable to swallow. Contact the palliative care team.

Other drugs can be added in the syringe driver, e.g. haloperidol, diazepam, antiemetics, etc. Add a combination laxative e.g. laxsol, lactulose, etc.

Fear of addiction in palliative care should not prevent under prescribing of pain control medications. Respiratory depression is not common.

#### Other opioids

- *Oxycodone* is available as OxyNorm (short acting 4-6 hours) and OxyContin (12 hours). More bioactive than morphine and less side effects. Oxycodone more useful for neuropathic pain. More flexible in its use.

2007 will see an injectable form. Care with renal failure – reduced by 50%.

- *Fentanyl* patches can be used every 3 days. Use in stabilised pain. This is expensive.
- *Methadone* – longer half life than morphine better use in people with renal failure.
- *Pethidine* – short action (2-3 hours) not much use in palliative care.
- *Tramadol* – a weak opioid. Use in post-operative pain. Nausea and other side effects.
- *DHC* – 10% metabolised to morphine. Max dose 240mg/24 hours. Then convert to morphine. Constipating.
- *Paradox* – weak opioid.

– Prepared by Dr Trevor Young  
– Edited by Catherine Yang



Hey everyone! It's come to that time of that year where exams are just around the corner for everyone~~hope no one's stressing out and everybody's managing fine^^...Just a little update on where we're up to in YACMA.

We recently had a CME dinner at Grand Park on the 15th October which had quite a good turn-out. The raffle tickets also managed to almost sell out on the CME night which was awesome! Thanks everyone who supported by buying some tickets!! Coming up in November just after everyone's exams (except the 4th years~~sorry!) is the end of year picnic/BBQ so keep your eyes on this spot as there will be more updates happening!! Until next time~all the best with everyone's exams!!

YACMA Committee