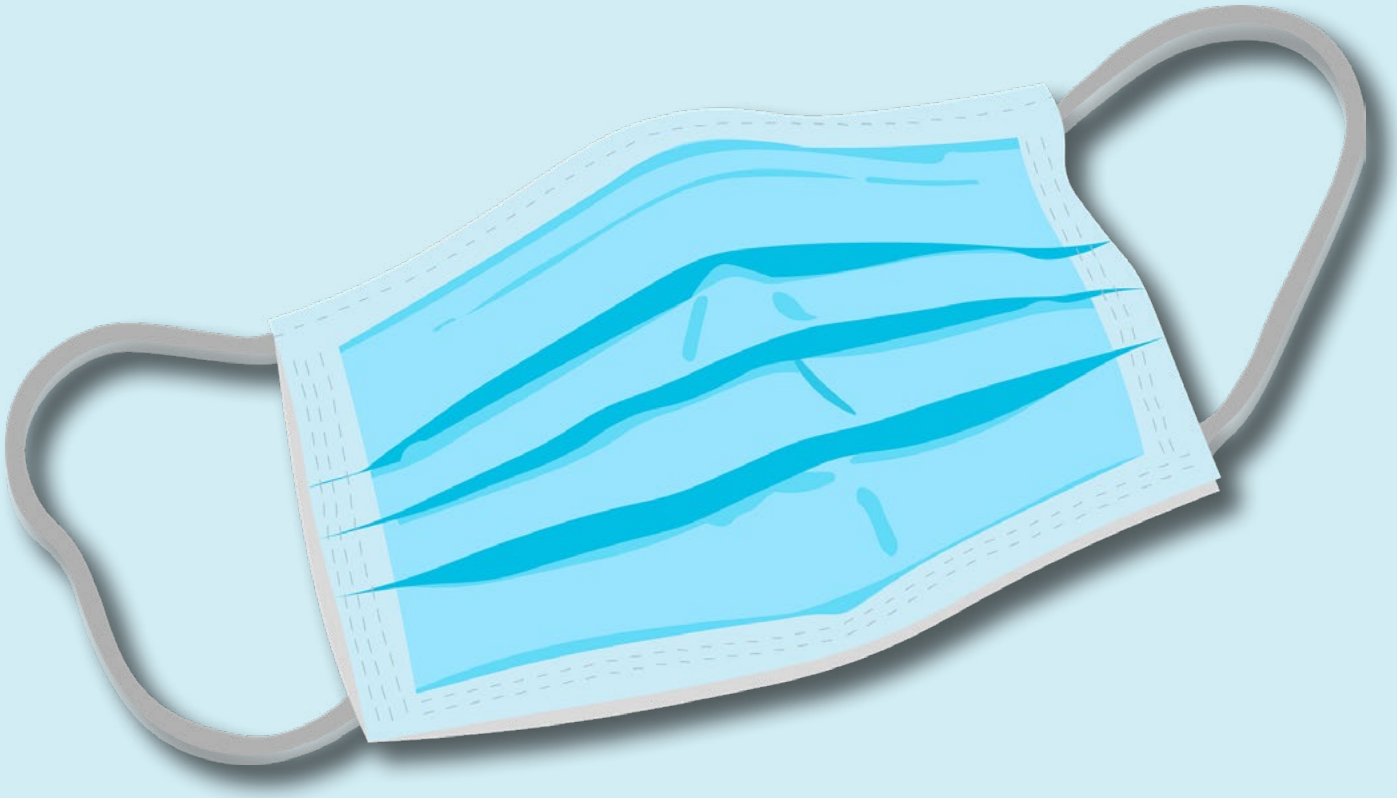
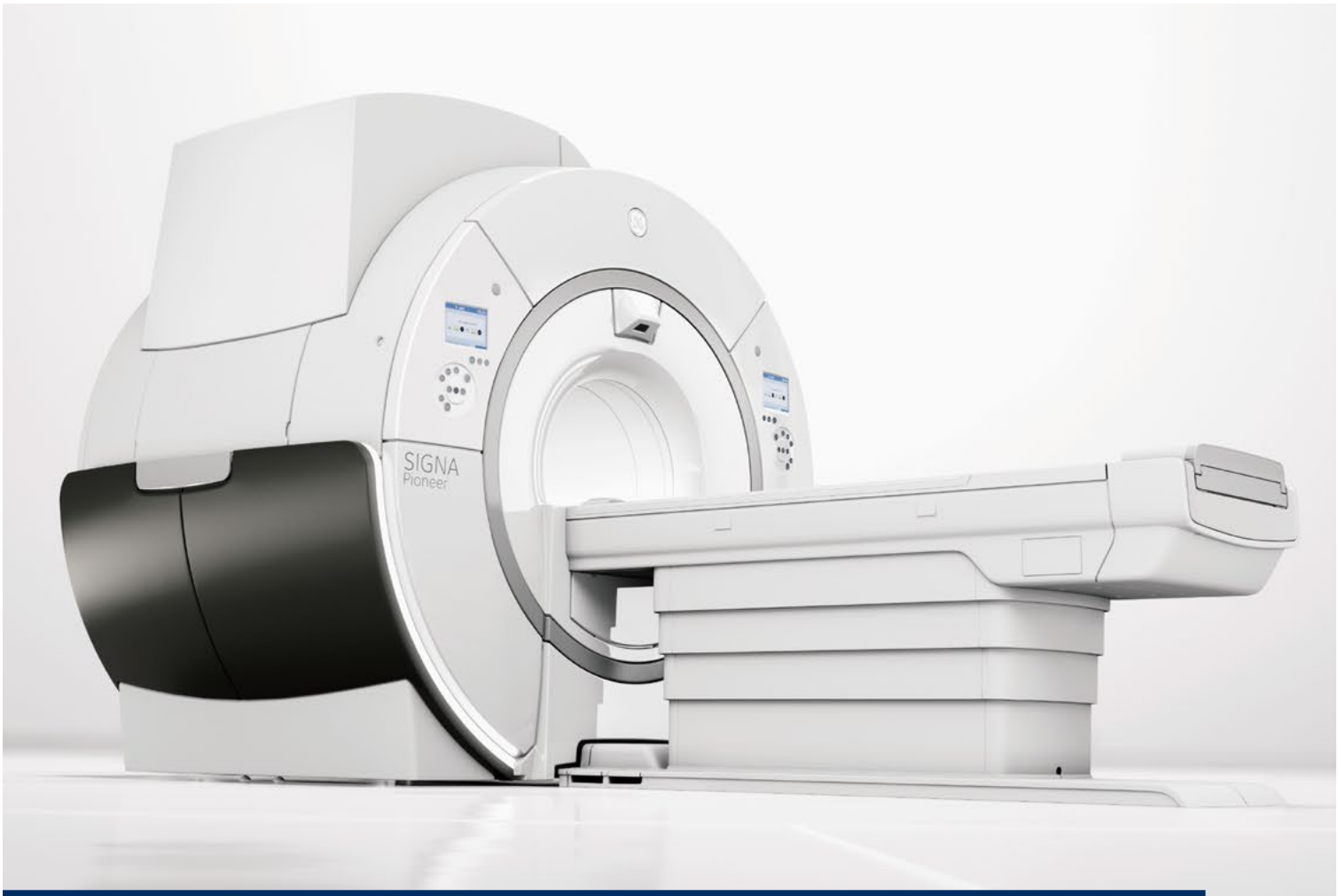
the medical link

Issue 133 | January — February 2021



THE INDEPENDENT VOICE OF MEDICINE
GCMA
THE GOLD COAST MEDICAL ASSOCIATION INC.

THE OFFICIAL PUBLICATION
OF THE GOLD COAST MEDICAL ASSOCIATION INC.
PUBLISHED BY SWAN MANAGEMENT



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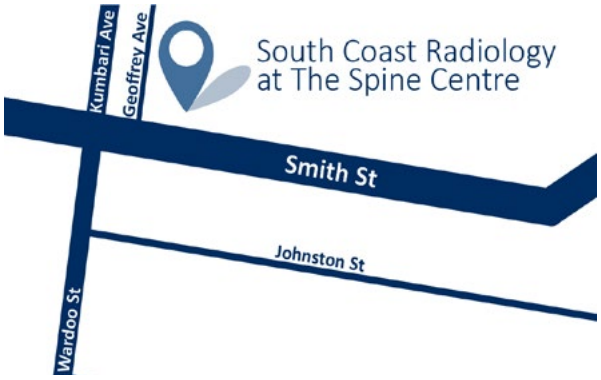

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SOUTH COAST RADIOLOGY

A message from the

GCMA President

Dear Colleagues,

Most of us are relieved to see the back of 2020. But as much as we hope for a brighter 2021, we will still be facing Covid-19 restrictions until the community is vaccinated to the level of immunity that stops onward spread of the virus. This will mean ongoing vigilance, maintenance of personal hygiene (and use of personal protective equipment as appropriate for medical professionals), physical distancing, taking a Covid-19 test at the sign of any symptoms however mild, avoiding workplaces when unwell, avoidance of super-spreading events, and wearing of masks as required when mandated by the government health authorities.

Vaccine roll-out will be first to older individuals and those with vulnerable health co-morbidities, and healthcare workers, aged-care workers and to emergency services personnel. Then vaccination will proceed on to the wider community. This may take some time, so I expect Covid-19 awareness and precautions will be with us for the majority of 2021. The GCMA will do its part to support the profession and the community as the year progresses.

Not all that happened in 2020 was on the negative side. I was so encouraged by the way we, as a medical and wider community, managed the pandemic in Queensland. The low overall rate of infections and the very limited mortality

was a blessing. This just goes to show how much can be done when citizens join together and cooperate under the guidance of public health advice. We have a lot to be thankful for. But the cost of all this caution has been a burden for business and employment. The focus on economic recovery must continue.

The GCMA has been active in preparing a schedule of meetings for 2021 now we can meet in person again. Our first Thursday evening dinner meeting will be on February 18 at 6.30pm at the Southport Golf Club. The topic is one that is on everyone's mind – 'Travel in the age of the Covid pandemic'. We have three excellent speakers lined up. I hope you can join us for this event. Meetings planned following February are outlined below.

18 March	Annual General Meeting, Dinner, An Update on the Vanuatu Hospital Rotary Project, plus Wine Tasting Tutorial
22 April	Panel: Indigenous Health
20 May	The Eyes Have It: Update on What's New in Ophthalmology
17 June	Attention Deficit Hyperactivity Disorder Overview
15 July	Interventional Radiology – An Update
19 August	Mental Health in the Time of Covid-19
16 September	Public Health with Dr Jeanette Young, Covid & Climate Change
14 October	Oncology Update
18 November	Panel: Careers Advice for Young Doctors
16 December	Christmas Party

At this early time of the year, our memberships of the GCMA are now due for renewal. Please go to the GCMA website to renew your membership, or send us your membership subscription by electronic funds transfer (EFT) to our GCMA General Account at our Westpac Ashmore bank branch, BSB 034-230, account number 203845. Make sure you put your identification on the transaction so we can send you a receipt. Please encourage your medical colleagues to join the GCMA. It is very easy – go to the GCMA website membership form section at www.gcma.org.au/becoming-a-member.

All the best for 2021! I look forward to seeing you again this year.

Professor Philip Morris AM

President GCMA

Dr Greg Seeley

has been practicing Clinical Haematology at the Gold Coast/Tweed Heads for more than 24 years.

His particular areas of interest are:

- Leukaemia
- Lymphoma
- Myeloma
- Venous Thrombosis
- Pregnancy Associated Haematology

He is the Senior Visiting Medical Officer - Haematologist at the Gold Coast University Hospital thereby providing clinical inpatient/ outpatient treatment at both public and private hospitals.

Greg has a dedicated history of providing an efficient, comprehensive and patient focused Clinical Haematology service for Gold Coast and Tweed/Northern Rivers patients & their families.

Please contact Greg by either phone on 0419 667943 or via Medical Objects for any haematology advice.

DR GREG SEELEY

MBBS Hons. (1st Class) (QLD), FRACP, FRCPA

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Keeping the medical community informed

The Medical Link enriches the Gold Coast medical community by uniting the voice of its doctors.

Here you will find insightful stories and the latest trends in field research conducted abroad, and of course, right here on the Gold Coast. Keep informed of new health services, developments in the medical profession, and general interest items.

We invite you to submit your company updates, new recruits and promotions to **info@themedicallink.com.au**

Contents

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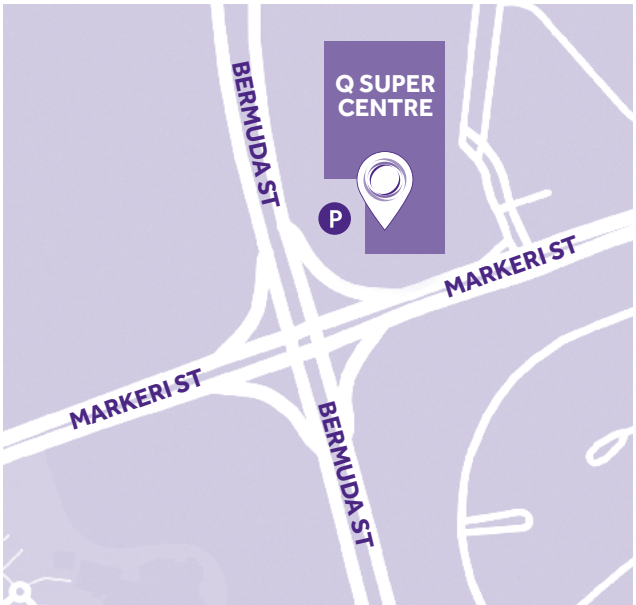

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Dr Robert Bourke **Retinal & Cataract Surgeon** Macula, Vitreous, Retina **& General Ophthalmology**

Dr Bourke is one of very few ophthalmologists who manage all complexities of cataract, macular and vitreoretinal eye surgery. After completing his Bachelor of Medicine and Bachelor of Surgery in 1984, Dr Bourke furthered his experience by completing two Vitreoretinal-Macular-Cataract Fellowships at Moorfields Eye Hospital (London) and St Paul's (Liverpool UK) between 1991-95.

Dr Bourke is a fellow of RANZCO and has authored several peer-reviewed journal articles and has been a guest lecturer at both national and international conferences. Dr Bourke has served the Gold Coast community since 1996 specialising in complex cataract, macular and vitreoretinal diseases.

Dr Lewis Lam **Retinal & Cataract Surgeon** Macula, Vitreous, Retina **& General Ophthalmology**

Dr Lam is a vitreoretinal specialist with a special interest in cataract surgery. While he underwent his vitreoretinal fellowship in NZ, he also undertook a diploma in laser refractive and cataract surgery with the University of Sydney. In addition to managing routine cataracts, he is adept at managing complex surgeries of the globe. In terms of general ophthalmology, he deals with macular degeneration, retinal vascular diseases, diabetes, uveitis, glaucoma, pterygium, trauma, and lid surgeries. Dr Lam also offers **evening clinics on Thursdays** till 8 pm and emergency weekend clinics. He is fluent in English and Mandarin and is happy to consult in either language as needed.

Dr Sharon Morris **Cataract, Oculoplastics & General Ophthalmology**

Dr Morris is an accomplished and friendly Eye Specialist and Oculoplastic Surgeon. After completing her training in the United Kingdom, she worked as a consultant at Moorfields Eye Hospital, a world leading eye hospital in London before relocating with her family to Australia. She is a Fellow of RANZCO and ANZSOPS and is actively involved in training future ophthalmic surgeons in her part time position at the Gold Coast University Hospital. She has published a number of medical articles, presented internationally and written a book chapter on orbital conditions.

Dr Morris provides comprehensive eye care in General, Cataract, and Oculoplastic eye conditions.

Dr Heather Russell **Cataract, Strabismus, General & Paediatric Ophthalmology**

Dr Heather Russell is a general ophthalmologist specialising in cataract, minimally invasive glaucoma surgery, double vision and strabismus, and paediatric ophthalmology. She also uses muscle-relaxing injections for blepharospasm, hemifacial spasm, and for non-surgical management of strabismus.

Heather trained in the UK and New Zealand before relocating to Australia to take up a position at GCUH where she continues as Senior Staff Specialist. She is a fellow of both RANZCO and RCOphth(UK). Heather has published widely, is actively involved in training doctors and medical students, and regularly presents both locally and nationally.

Dr Alan Hilton **General Ophthalmology, Paediatric Ophthalmology & Strabismus**

Dr Hilton has worked in private practice since 1970. He has a worked in a number of Hospitals in Queensland and has also been the chairman of Ophthalmology Assessment Tribunal for Q Comp. In conjunction, Alan has been a lecturer and examiner at a number of Universities and Medical Institutions in Australia. As well as General Ophthalmology, Alan has a special interest in paediatric ophthalmology and strabismus.

Dr Hilton is a Fellow of the RANZCO and member of a number of colleges and associations, including the Royal College of Surgeons Edinburgh and Royal Society of Medicine London.

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Eye Specialist Institute

Dr Sharon Morris

BM MRCSEd FRCOphth FRANZCO ANZSOPS

Consultant Ophthalmologist & Oculoplastic Surgeon

Floppy Eyelid Syndrome

Do you snore or have congestive airway disease and are your eyes gritty, dry and irritable? Do your eyes water? Have you tried a number of drops and treatments but your eyes still feel the same? **Chances are, you have Floppy Eyelid Syndrome.** This condition is very under-recognised, yet is often the cause for eye discomfort, watery eyes, gritty eyes, droopy eyelids, puffy lower eyelids and lid malposition.

Pathophysiology

Floppy eyelid syndrome (FES) is a horizontal loosening of the eyelids, both upper and lower. This usually occurs in people with obstructive sleep apnoea (OSA), but can occur in obesity, other congestive airway diseases, chronic sinus disease, allergic disease, keratoconus and Down's syndrome.

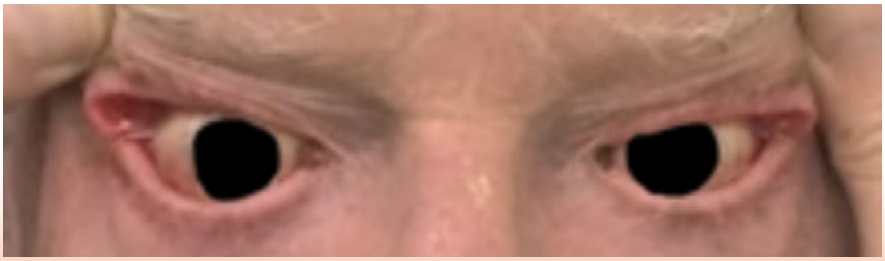
Mechanically, if the eyelids are loose on the horizontal vector then the natural blink tone of the lid is altered and this causes roughness or irritation to the eye surface. I liken it to a "raggedy wind-screen wiper on the car windscreen".

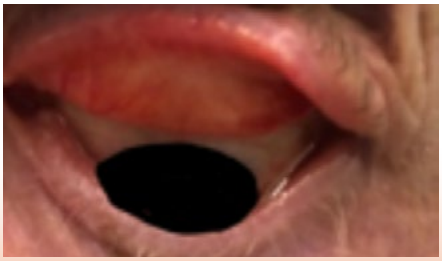
The inside linings of the eyelids become irritated and inflamed and the quality of the eye tear film is reduced. There may be a mild mucous production.

When the eyes are irritated on the surface they often present with sudden bursts of tearing spilling down the cheeks. Sometimes the eyelids are so stretchy that they easily evert/turn inside out! Sometimes they lift open by themselves during the night and the eye gets exposed or rubs on the pillow!

Potential consequences

The eyelids are the first defence to the eye – compromise of this protection and the eye is exposed to abrasions, infections and blindness of the eye. This patient has marked looseness of the upper eyelid tone such that a simple sideways distraction of the lid will reveal the inside lining tarsal conjunctiva. The conjunctiva is reddened and inflamed.





Potential consequences

Patients with floppy eyelid syndrome have loss of elastin in the eyelid but the pathophysiological processes behind this are not fully understood. Over time, chronic obstruction of the airways causes 'back-pressure' around the orbit, orbital fat and eyelid skin. This also causes the lids to puff out or become full and sometimes the lids will have festoons – pockets of fluid that fluctuate with position.

The lid skin stretches and they become heavy. Commonly the change in the tone leads to ptosis (droopy lids), excess skin and lower lid ectropion (lids displaced downwards or outwards).

Treatment

Treatment is multifactorial. Unfortunately, there is not one quick fix to solve the symptoms. Firstly, the underlying cause needs to be assessed for otherwise the disease process will perpetuate. OSA is associated with increased risk of stroke and death, as well as glaucoma. Driving ability can be severely compromised during the day due to daytime somnolence from poor sleep patterns. Treatment depends on the level of severity of the airway obstruction and may simply need weight loss or a change in sleeping position. Sleep studies assess the disease and, if severe, usually a C-PAP or BiPAP breathing device is recommended. The masks and fit around these are very important as a poorly fitting mask will often escape air onto the eye surface damaging the eye further and the pressure of a tight large mask can increase the fluid fill of the eyelid. However, treatment of OSA is crucial to reduce the life-threatening risks.

Secondly, the ocular inflammation and poor tear film needs to be addressed. I usually start patients on a preservative free lubricant 4 times daily with a night-time gel tear substitute as a baseline treatment. This will improve the quality of the base tear film and reduce the sudden reflex hyper-tearing responses. It will also start to reduce the inflammation from the mechanical abrasion effect. If a patient presents with a marked papillary inflammation of the tarsal conjunctiva, I will add in a low dose steroid drop twice daily eg. FML. Some patients with notable eversion of the eyelid at night may wish to tape their right and then left eyelids closed on alternate nights to prevent exposure or use a gel foam dressing to occlude the eye. Switching sleeping positions to the opposite side from the worst eyelid features is beneficial.

Finally, if the simple conservative and supportive methods of the tear film do not improve the overall symptoms, then surgery should be considered. Surgery is usually staged as all four eyelids usually need to be addressed. The lower and upper lids need horizontal tightening, usually with lateral canthal tendon plication or wedge resections. Often the upper lid will override the lower lid margin due to the laxity until the upper lids get fully corrected too. Once healed, the secondary ptosis or excess skin can be addressed. These surgical techniques usually dramatically improve the comfort and blink of the eye and reduce the ongoing need for eye drops. However, most patients will require some form of ongoing lubrication to the eyes and if the underlying cause goes unchecked the features will reappear with time.

Research is currently exploring whether cross-linking techniques (riboflavin tissue soaks irradiated with UV light) will stiffen the elastin deficient tarsal plates of the eyelid, thereby reversing some of the features of floppy eyelid syndrome and improving the long-term stability of the eyelid.

Restoration of the eyelid function is critical to protect the eye. Treatment of the underlying cause can be life-saving. Look out for the floppy eyelid!

New General Manager Takes the Reins at Gold Coast Private Hospital

Gold Coast Private Hospital has welcomed new general manager Kimberley Pierce to oversee the 314-bed Healthscope-operated facility off Parklands Drive, Southport.

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Ms Pierce comes from a seven-year tenure as chief operating officer at Gold Coast Hospital and Health Service (GCHHS) and takes over as general manager from David Harper, who was at the helm since 2011 and is now Healthscope state manager for Queensland, Western Australia and Northern Territory.

Mr Harper led his team during the planning and construction of Gold Coast Private Hospital, facilitated the move from its former facility, Allamanda, and spearheaded the introduction of new services including neurosurgery, maternity and a special care nursery.

Ms Pierce said Gold Coast Private had a great reputation and she was looking forward to leading such a well-respected hospital.

"As COO for GCHHS, we did a lot of work with private facilities on the Coast and, without a doubt, Gold Coast Private was the most proactive to work with," she said.

"I have had the pleasure of working with former general manager David Harper, who was always happy to help at short notice and this 'can-do' attitude is something I've always respected about Gold Coast Private Hospital."

Ms Pierce spent many years working in the private sector in the United Kingdom, South Africa and Australia before taking on her role with Gold Coast Health.

"I like Gold Coast Private Hospital's patient-centred approach where the focus is on staff satisfaction and the patient experience," said Ms Pierce.

"I also like the management structure, which means I will be working a lot more closely with the medical staff."

Like her predecessor, Ms Pierce began her career as a nurse and climbed the ranks through positions including director of nursing and executive director of surgery and critical care.

She said her clinical background was a significant advantage.

"Having that intricate knowledge of how a hospital works is invaluable and I think crucial if you want to lead one," said Ms Pierce.

"Whenever you bring in a service, you have to understand all the interrelationships between the various departments and with my background, I can assimilate all the moving parts quickly.

"It also helps me to connect with staff as I've grown up through nursing. I've been in the roles, I understand the challenges and I know the importance of the back-of-house teams and understand how integral they are to running a ward."

Since opening in 2016, Gold Coast Private Hospital has continued to expand its capacity and services and now has 21 operating theatres, a day surgery centre and space to increase to 400 beds in line with demand.

The hospital is a national leader in patient satisfaction and has a global Net Promoter Score (NPS) that puts it in the 'world class' category for patient experience, with up to 93.2 per cent of patients rating their stay 'five out of five' stars.

Ms Pierce said Gold Coast Private's biggest asset was its people and she was looking forward to leading such an engaged team.

"There are a lot of strengths here but staff culture is the best I've seen and having that level of engagement makes a huge difference for patients," she said.

"When we look at patient experience it's more often judged by what's happened on the ward - the care, the meals and so forth.

"The fact this hospital team really respects each other and works together to make the patient experience a memorable one is a huge strength that sets Gold Coast Private apart."


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1. GenesisCare. National prostate SBRT treatment protocol. September 2019. Data on file.
2. King CR, et al. Radiother Oncol 2013;109:217–221.
3. Kothari G, Loblaw A, Tree A et al. Stereotactic body radiotherapy for primary prostate cancer. Technol Cancer Res Treat 2018;17: 1533033818789633. DOI: 10.1177/1533033818789633

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Relocation assistance to the Gold Coast will be considered for suitable applicants.

For a confidential discussion contact Kenny Craig, Chief Executive Officer, Robina Private Hospital on 07 3254 9100 or email kenny.craig@healthecare.com.au

Now recruiting for consultant psychiatrists

Eating disorders specialist

Robina Private's 10-bed eating disorders unit has a well-deserved reputation for excellence. Our specialist multi-disciplinary team of practitioners deliver contemporary and evidence-based treatment options for people suffering from a range of eating disorders.

Two eight-week outpatient day programs offer an intensive program for Anorexia Nervosa and Bulimia Nervosa; and for Binge Eating Disorder.

Robina Private's eating disorders service was established by psychiatrist and director of the service, Dr Vinay Garbharran, and psychologist and clinical lead of the day programs, Dr Kim Hurst, who both have their private practices at the hospital.

We are currently the only private hospital in Queensland offering such a comprehensive eating disorders program.

Acute adult mental health

With 80 dedicated acute mental health beds, Robina Private Hospital provides expert care to manage and treat a wide range of mental health disorders.

We offer a holistic approach with treatment provided in a safe, supportive environment for inpatients, day patients, outpatients and new hospital-in-the-home services. Our specialist services include:

- A 10-bed eating disorders unit providing the highest standard of treatment by a specialist multi-disciplinary team of practitioners; and
- A 10-bed older persons specialised care unit delivering specialist care by psycho-geriatricians and a specialist multi-disciplinary team of practitioners for patients experiencing mental health problems co-morbid to their neurocognitive disorder.

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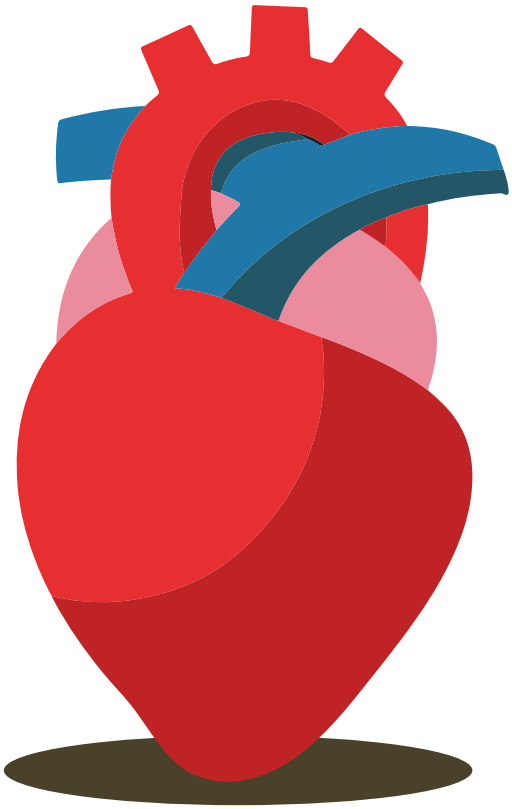

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Managing Gender Dysphoria / Incongruence in Children & Adolescents: A Perspective for Debate

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1 This approach to managing gender dysphoria [1] or gender incongruence [2] in children and adolescents aims to protect and safeguard the health, safety and welfare of the child. These guidelines prioritise the best interests of the child in accordance with human rights obligations under the International Convention of the Rights of the Child [3].

2 Gender dysphoria/incongruence in young people is a debated area of medical practice. This approach avoids political, social or religious ideological positions.

3 As health professionals this approach acknowledges and respects young people's views about their gender identity, as part of the totality of their developmental and holistic clinical picture, and incorporates these into the clinical formulation. This approach requires that a comprehensive bio-psycho-social assessment be conducted before recommending specific treatment.

4 The approach appreciates that childhood and adolescence is a time of rapid physical and psycho-social growth and profound personal development. It is characterised by examining many aspects of identity, including sexual orientation and gender. As the child matures and progresses through puberty this questioning usually transforms and resolves and the young person, in the majority of cases, accepts his/her biological sex and adult body [4,5].

5 The approach recognises that gender dysphoria/incongruence can often be a manifestation of complex pre-existing family, social, psychological or psychiatric conditions. A holistic approach i includes a comprehensive exploration for these potential conditions in order to more fully understand a child presenting with gender dysphoria/incongruence [6].

6 Extensive assessment of family, social, psychological and psychiatric factors is an essential step in effective and safe management of children and adolescents presenting with gender dysphoria/incongruence.

7 The approach proposes that psychotherapy should be a first-line treatment for young people with gender dysphoria/incongruence. This intervention should be undertaken before medical interventions (puberty-blocking drugs, cross-sex hormones, sex reassignment surgery) are planned.

8 The approach is aware that medical interventions to block puberty and to achieve feminization and masculinization according to the young person's perceived gender are not fully reversible and can cause significant adverse effects on physical, cognitive, reproductive and psychosexual development [7,8,9,10,11,12,13].

9 Currently, while some individuals report a successful transition, we are not aware of published long-term outcome studies that have followed up adults who have undergone childhood or adolescent transition that show substantial benefit. As a consequence, there is no consensus that medical treatments such as the use of puberty-blocking drugs, cross-sex hormones or sexual reassignment surgery lead to better future psychosocial adjustment [14,15,16,17].

10 Increasing numbers of individuals who have undergone hormonal treatment and surgical interventions subsequently report experiencing regret and a wish to de-transition. They describe significant psychological and physical suffering, including loss of fertility and sexual function as a consequence of decisions made when younger [18,19,20,21,22,23].

11 Clinicians should therefore reflect carefully before contemplating or recommending treatments for gender dysphoria/incongruence, including irreversible medical interventions.

12 The still unproven risks and benefits make it imperative that parents and children and adolescents are made aware of the current evidence regarding gender transition and provide fully informed consent before potentially damaging and irreversible treatment is commenced.

13 This cautious approach is also mirrored in general clinical guidance by national bodies that recommend health services for public funding [24].

In preparing this statement advice was obtained from a number of senior medical colleagues in child and adolescent psychiatry, adult psychiatry, forensic psychiatry, and from physicians who have cared for individuals experiencing gender dysphoria/incongruence.

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(continued overleaf)

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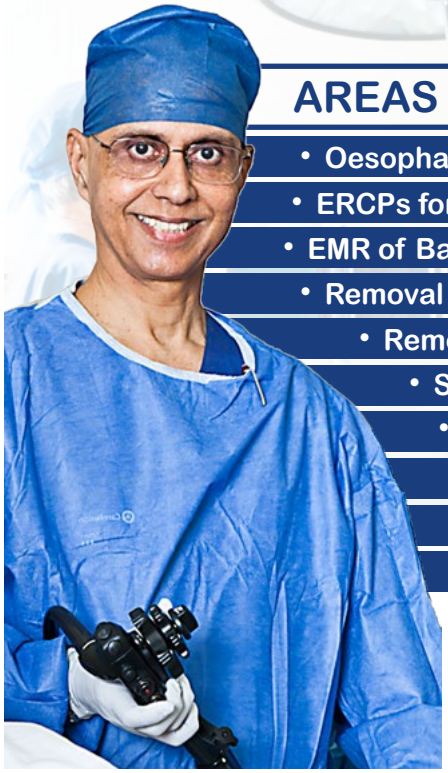

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That being said, the association of chronic PPI use to adverse events in observational studies does not establish a causal relationship given residual confounding.

Randomised studies of Paul Moayyedi (Gastro 2019 05 056) brings some clarity to widespread concern regarding PPI adverse effects. They prospectively randomised 17,598 cardiovascular patients to receive pantoprazole 40mg daily (8791) or placebo (8807) on either rivaroxaban and aspirin or rivaroxaban alone or aspirin alone. The median follow up was 3 years.

There was no statistical difference between pantoprazole and placebo groups with respect to cardiovascular events, hospitalisation rate, gastrointestinal cancers or other health conditions with the exception of enteric infection being (marginally) more common in the pantoprazole group. Clostridium difficile infection was more frequent in the pantoprazole group but did not reach statistical significance. This randomised study was criticised for not being adequately powered (17,598) and for not being followed up for long enough (3 years).

In mine and others' anecdotal experience, I think that it is reasonable to conclude that serious adverse events are unlikely when using PPI, with the possible exception of interstitial nephritis.

Enteric infections are also a possibility. I would recommend the following for the safe use of PPIs:

- Avoid long term use of PPI for gastric/duodenal ulcers and grade A mild erosive oesophagitis.
- Use low dose PPI such as pantoprazole 20mg/rabeprazole10mg/lansoprazole 15mg/omeprazole 10m daily in patients with mild GORD A without hiatus hernia.
- Consider using H2RA e.g., nizatadine(150m)/famotidine 20mg daily when endoscopic information is not available.
- Repeat endoscopy if patient is symptomatic on PPI. Tachyphylaxis is a real issue with relapse of GORD and change of PPI plus minus H2RA may be required based on endoscopy.
- Gastric cancer of the intestinal type is rapidly declining in the Caucasian population in Australia and is of concern mainly in the Asian population, which is perhaps related to H.Pylori and not due to PPI use.

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For bespoke design projects it is highly recommended you engage an architect who will not only deliver you with a design that meets your functional and aesthetic needs, but just as importantly, a design that meets your budget.

Unfortunately, by its very definition, bespoke design is unique and will comprise numerous variables that impact the construction price including the following.

Construction Methodology

The main two factors contributing to building cost are materials and labour. To a large degree, residential construction methods and building materials have changed very little for centuries, and as such, builders have become comfortable with the costs associated with both, so can estimate building prices fairly accurately.

Unfortunately, if new building systems or unusual materials are proposed as alternatives to conventional construction they tend to be more expensive, despite the fact that they may offer obvious benefits such as reduced building time. This can be due to increased costs as a result of limited supply and demand, reduced competition because many builders are reluctant to change the status quo, or uncertainty about potential issues that could arise during construction resulting in increased material or labour costs.

Anyone who has visited a building site will immediately notice the large amount of waste filling skip bins that need to be emptied on a regular basis throughout the construction process. These wasted materials have all been paid for by the client, so reducing or eliminating this waste will also reduce the building cost. This is one of the reasons modularisation and prefabrication are seen as integral to sustainable building practices in the future.

Whilst the builder or tradesmen are responsible for estimating the materials they need for any job, design obviously plays an important role. Most materials or components are produced in standard sizes, so designing within the parameters of these sizes not only reduces waste, but also ensures economy in cost as a result of the efficiencies that can be achieved through mass production.

Most builders are trained as carpenters which provides them with a wide range of construction skills enabling them to build a large proportion of any home without the need to engage other specialist trades. The more unusual the materials or services adopted in a design, the greater likelihood that specialist trades will be required. The more trades required on site, the more expensive the construction is likely to be.

Traditional construction systems also vary considerably in price as a result of differences between material, labour and installation costs. As an example, lightweight materials that can be handled manually on site are generally cheaper and easier to install than heavier components which require heavy lifting equipment or machinery.

To reduce material and labour costs, the following are some helpful design principles that should be considered:

- Building on a sloping site is more expensive than a flat site.
- A simple building footprint is cheaper than a highly articulated building form.
- Single storey is cheaper than multi-level construction primarily due to scaffolding costs.
- Standard ceiling heights are based on plasterboard sheet widths which minimise material waste and labour costs.
- Wet areas and joinery are big cost items.

• Lightweight construction is cheaper than masonry construction.
• A suspended timber floor is much cheaper than a suspended concrete floor.
• Horizontal sliding windows are the cheapest openable window option.
• Choose standard size windows and doors.
• Grouping wet areas together reduces plumbing and drainage costs.
• Align loadbearing walls between levels where possible in multilevel buildings.
• Avoid excessive spans / room sizes where possible.
• Timber structural members are generally much cheaper than steel (of a similar size) and can be managed easier on site.
• Roof pitches beyond 25 degrees incur additional costs due to installation safety requirements.

Preliminaries

There are also other less obvious costs associated with building that need to be considered. Preliminaries (prelims) are site costs that are directly related to the running of the project but which are not accounted for under labour or material. They are the cost of the site-specific overheads for any given project and include items such as:

• Welfare provision for on-site staff – temporary toilets & other facilities.
• Connection of temporary utilities such as power & water.
• Equipment & machinery hire including items such as security fencing, scaffolding, security, digging or lifting equipment.
• Rubbish disposal including skips and end of project building / site clean.
• Personnel costs for staff working on the project such as a site foreman.

Typically larger construction companies have higher preliminary costs than smaller 'hands-on' builders who don't need to employ additional staff to manage their projects.

Overheads, Profit & Margin

There are further costs that make up the final building price. Overheads (different to preliminaries) relate primarily to the costs of running the building company including office rent, office expenses, office staff, licenses, insurances, accounting, and legal fees.

Profits are self-explanatory, and every business relies on making them to survive.

Margin is either a lump sum fee or a percentage applied to the estimated cost of performing the work which includes allowances for overheads, risk and profit. The margin is often not disclosed but is built into the overall cost, and typically varies from 10% to 20%.

As with preliminaries, larger building companies will need to operate on a higher margin to cover their overheads and risks.

Cost Planning

Understanding the many variables that influence the cost of building is important when designing to a budget. However, only after estimating the cost of the design will you know if you can build within the budget allocated. The sooner this can be done the better.

For new buildings, applying construction rates (cost per square metre) to the building area can be a useful starting point. These rates will be based on historical data garnered from similar projects completed in the past, however as every custom designed project is different, and market conditions vary over time, they should only ever be used as an indicative guide. In some cases, like renovations, they may not be applicable at all. This is because renovations typically comprise numerous hard to quantify costs.

There are 'lost' costs for demolition work, nil material cost for retention of existing built structure but additional costs for 'making good' to match new work, increased costs for building within the constraints of existing structure, and repair costs associated with unforeseen latent conditions.

So how do you establish a building cost? Whilst architects are skilled professionals, they are not trained as building estimators or cost planners. Comparable to undergoing surgery, as a patient you would need to engage an anaesthetist to prepare you for surgery, and then a surgeon to undertake the operation. You may have the choice to forgo the anaesthetic, but the consequences could be dire.

Similarly, with designing a new home or renovating, if your budget is critical, then you are well advised to engage a specialist cost planner to perform this role early in the process to avoid future pain. There are several cost planning options you can consider.

Specialist Cost Planners or Quantity Surveyors are trained to perform this role. They will use the design drawings to measure quantities of materials, apply labour rates for the respective trades, calculate preliminaries, and include a margin based on existing market conditions. Builders either engage Cost Planners to establish their building quotes or have the requisite skills to do it themselves.

That provides another option. You engage directly with a builder to provide this cost planning service for an agreed fee. Once the cost plan is completed, you can either elect to proceed with the builder to contract or choose to tender the project to other builders with the knowledge that you have one price already confirmed. Not all builders will accept this arrangement, but many will, reliant on building the trust required to win the job during the cost planning process.

Having a cost planner involved early in the project allows you to make informed design decisions throughout the various design stages, and to avoid the disappointment of discovering at the end of this often-lengthy process that you cannot afford to build what has been designed and documented.

At LDS, we have been involved in designing a wide range of residential dwellings, from economical flatpack emergency disaster relief shelters, to multimillion dollar mansions, so we understand the importance of designing to a budget. We can design you a Sydney Opera House if budget permits, however there is little point if the budget only allows you to build the stage.

There is considerable time, emotional, and financial capital expended on designing a new home, so, do it right, do it once, and the experience can be very rewarding.

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Dr Pilgrim completed her medical training at Bond University and speciality training in Queensland, gaining expertise from rural and tertiary hospitals. She is a fellow of the Royal Australian and New Zealand College of Obstetrics and Gynaecology with more than 10 years of experience in healthcare for women.

Grace Private co-founding director Dr Tina Fleming welcomed Dr Pilgrim as a valued addition to the Grace team which now includes five obstetrician and gynaecologists, a gynaecological oncologist and an endocrinologist. The team is backed by physiotherapists, dietitians, psychologists, nurses, midwives and sonographers all under one roof.

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