RDMA
REDCLIFFE & DISTRICT MEDICAL ASSOCIATION
Newsletter
August 2010

German Medical Students' First Day at the RNA & Brisbane City

Carolin Gersthahn (pictured on the eft) and Sarah Kaeter (pictured on the right) are two medical students from Germany who wanted to do an 8 week elective placement in Australia.

They wanted to gain the experience of every day life in an Australian Hospital. They share their insight and first views of the Royal National Show and the City. See their pictorial on page 20.

RDMA President's Message ... Dr Wayne Herdy

Friends and colleagues, ladies and gentlemen, welcome to the inaugural edition of the Redcliffe and Districts Local Medical Association Newsletter.

This publication marks a milestone in the growth of REDAMA. Nearly thirty years ago, I used to receive a 4-page monochrome sheet, probably roneoed (that shows some familiarity with ancient, long-extinct, technology). We progressed through a brighter and bigger local newsletter to a publication which served a much larger geographic area.

Unfortunately, the newsletter that you have been receiving for the past few years was no longer a local newsletter. It was no longer exclusive to our organization. We did not have editorial control over its content or its distribution. Much of its content was generic and not specifically relevant to our particular group. Its distribution no longer coincided with our meeting dates.

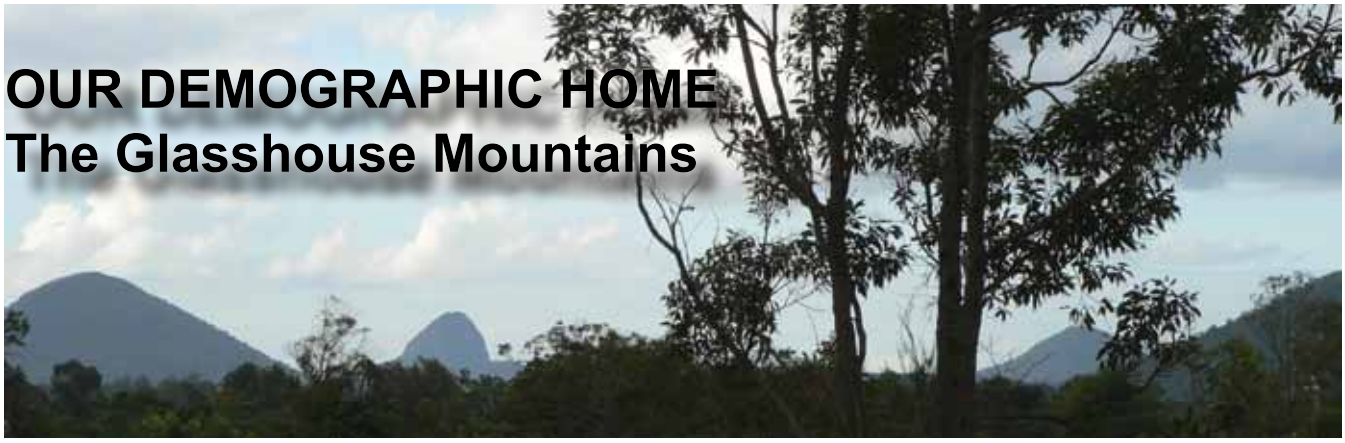
This new publication before you is OUR newsletter. Its content is mostly locally sourced and all locally relevant. It gives news about OUR Association, and issues important to members of OUR local professional population.

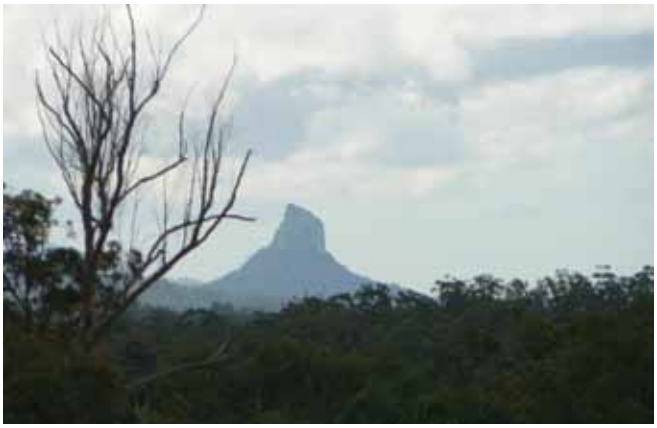
As President of the Redcliffe and Districts Local Medical Association, and de facto inaugural Editor of the new-look local newsletter, I invite you, our local doctors, to contribute articles and letters to the Editor. Articles can be about clinical matters in your own area of practice, political or business matters with wider application to all doctors, or non-medical articles about your hobbies or interests that might be of interest to medical practitioners or anybody else. Letters to the Editor will be welcomed, but the Editor of any publication reserves the rights (a) to publish or not publish, (b) to exclude material, as long as the sense of the letter survives, and (c) to give an editorial reply.

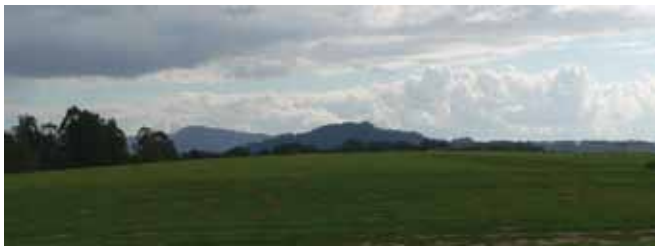
This is YOUR newsletter, about YOUR Association. Enjoy it, and be part of it.

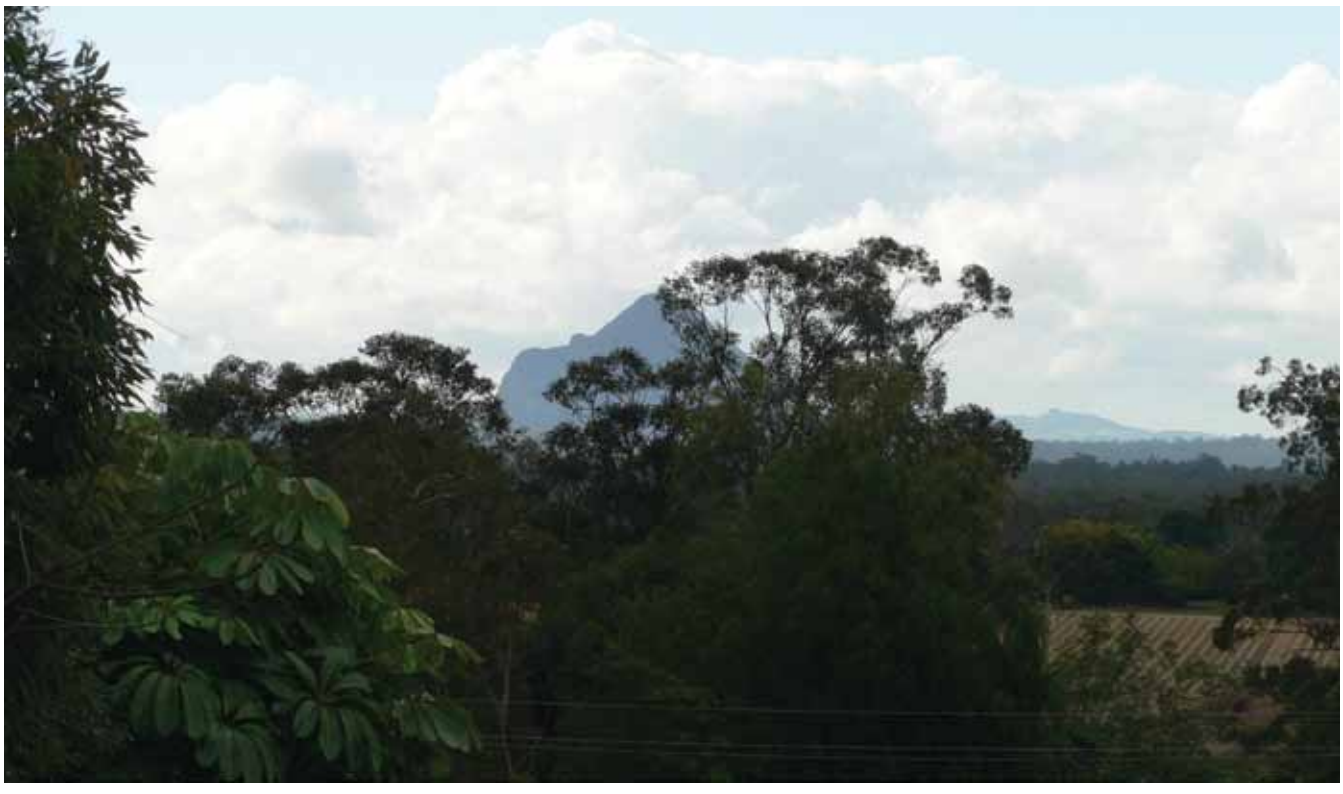
Wayne Herdy, President,
Redcliffe & Districts
Local Medical Association.

OUR DEMOGRAPHIC HOME
The Glasshouse Mountains









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Notice of Interest

Redcliffe & District Medical Association Ltd

CABOOLTURE BRANCH MEETING

Last chance to show your support? If you like the idea of a local medical association, here's the opportunity to come along and show your appreciation on the night.

Date: Wednesday 8th September 2010
Venue: Caboolture Sports Club, Centenary Lakes, Morayfield Road, Morayfield
Time: 7 for 7.30 pm
Speaker: Dr Wayne Herdy, AMA Federal Councillor, Member of AMA Public Health Committee
Topic: Preventive Medicine, Policy and Practice

SEPTEMBER NEWSLETTER 2010

The 10th September 2010 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com or Fax: (07) 5429 8407

THIS NEWSLETTER

Thank you to the following members for their contibutions:

- Dr Philip Dupre's article on "The Origin of Life".
- Dr Andrew Houston's "Delusion" article and
- Dr Mal Mohanlal's article on "Damned if You do and Damned if You Don't"
- Dr Troy Gianduzzo's article on "PSA Testing Update for General Practitioners.

New members: Once accepted at an RDMA Committee meeting, new members are asked if they would like to introduce themselves to the Association via the monthly newsletter. We look forward to introducing any new members to the organisation in the next addition.

INSIDE THIS ISSUE:

Fundamentals Support Ongoing Economic Recovery

As noted in our published Quarterly Investment Strategy – the world economy is, in our view, recovering as well as can be expected. The US economy has returned to trend growth rate (GDP) of 2.5%; the Chinese economy remains above its trend growth rate of 9.9%; and even Europe has returned to economic growth during the quarter, albeit below its trend growth rate of 1.2%.

With Australia's major trading partners growing, unsurprisingly the Australian economy (GDP) has grown 2.7% during the 12 months to March 2010 with an expectation that it will easily exceed its 3.1% GDP trend growth trend over the coming year.

Based on these growth projections and underlying forward company earnings forecasts suggests that the ASX200 will appreciate around 20% toward 5300 points over the next year.

RBS Morgans – Redcliffe Ph: 3897 3999

DATE CLAIMERS :

For all queries contact Tracey: (07) 3049 4429

Event: Annual General Meeting 25/08/10
Venue: The Ox, 330 Oxley Ave, Margate
Time: 7 for 7.30 pm
Sponsor: MundiPharma
Speaker: Dr Geoff Harding
Topic: "National Pain Strategy Update"

Event: RDMA Meeting 14/09/10
Venue: The Ox, 330 Oxley Ave, Margate
Time: 7 for 7.30 pm
Sponsor: Sanofi Aventis Diabetes Team
Speaker: Dr Matt Rickard, TPCH, Department of Medicine
Topic: Basal and Beyond - Optimizing Insulin Regimes in Type 2 Diabetes

Event: RDMA Meeting 27/10/10
Venue: The Ox, 330 Oxley Ave, Margate
Time: 7 for 7.30 pm
Sponsor: Pfizer
Speaker: TBC
Topic: TBC

Event: Year End Networking Function 26/11/10
Venue: Sails Function Rooms, Suttons Beach Parklands, Redcliffe
Time: 7 for 7.30 pm
Sponsor: QML Pathology

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT
Dr Gino Pecoraro

Hospital performance update

Late last year AMA Queensland developed the Your Hospital's Health website so that our members and the general public could easily see how each public hospital was performing based on the Quarterly Public Hospitals performance report released by Queensland Health. The website provides a vital opportunity for Queenslanders to learn more about the State's hospitals, the mounting pressures on our hardworking doctors and nurses, and the issues affecting the treatment of our patients.

The June quarterly performance report was released this month and AMA Queensland updated our website with the new data. Through the website you can access key data on bed occupancy, the number of people waiting for elective surgery, average emergency department admission times as well as other useful information.

Overall Queensland Health has indicated that since the last quarter report in March there has been an increase in patient admissions and a decrease in the times patients are waiting to receive elective surgery.

As AMA Queensland President I pride myself on being honest about the health system and while these figures are seemingly positive, there are a few inconsistencies which I would like to highlight.

Unlike the March Quarter report, there is no mention of how many patients are waiting to be seen for an initial appointment in a public specialist's outpatient clinic. Waiting to get on the waiting list is a large concern and it is disappointing this data was not included in the current report. To truly understand how our hospitals are performing and to identify those areas that require larger focus, the demand on specialist outpatient clinics needs to be brought into full public view. AMA Queensland is currently seeking this information from Queensland Health through a Right-To-Information request.

The second issue I have with the report is the way elective surgery waiting times is presented. Overall these figures look to be decreasing, however at a closer look the reason for this is due to the large focus on category 3 surgeries.

Caboolture Hospital has actually seen an increase in the number of patients waiting for elective surgery from 650 patients in March to 675 patients this quarter. The number of patients on the 'long wait' list has also increased.

Redcliffe Hospital on the other hand has seen a decrease in the wait times from 160 patients on the long wait list to 76 but the data still reflects a large focus on Category 3 patients rather than the more urgent Category 1 and 2 cases.

Redcliffe and Caboolture Hospitals both have seen an improvement in the time it takes for patients to be admitted at the Emergency Department. This quarter sees 75% of patients admitted within 8 hours of arrival at the Emergency Department compared with 73% in March 2010.

Caboolture Hospital now shows 72% of patients being admitted within the 8 hours of arrival at the Emergency Department compared with the last quarter where only 66% were being seen in this time.

AMA Queensland believes in communicating this data to patients and doctors, and it is our responsibility to flag areas of concern to Government so that the health system is operating as best it can. It is so important that local doctors communicate with their local representative so that AMA Queensland is given an excellent picture of where problems occur or when things are working well.

At a local level it is the responsibility of our members to indicate when they feel the system is lacking.

With this in mind, I take this opportunity to personally acknowledge Dr Wayne Herdy as he has once again been elected as the North Coast area representative on AMA Queensland Branch Council for a fourth term.

As AMA Queensland President, I rely heavily on our local representatives to bring the issues and concerns of the doctors in their area to our attention. Dr Herdy is particularly active in the area of Ethics and Medico-Legal matters, continuing to Chair our committee that drives our organisation's positions on those often difficult and sensitive issues.

Dr Herdy is of course your Redcliffe District Local Medical Association President but also is the Queensland area representative on AMA Federal Council. He is well placed to represent the North Coast area and I urge all colleagues to pass your concerns so that we can continue to represent your views.

THE ORIGIN OF LIFE

Dr Philip Dupre

Reprint: Dr Philip Dupre tendered an article which was printed in the previous newsletter, unfortunately the final article contained a number of typos for which the editoral staff accept full responsibility. Dr Dupre has kindly allowed us to reprint his article with all typos amended. We hope you enjoy the article and the associated letter to the editor too.

The generally accepted theory is that life originated when complex organic compounds were formed by chance out of an inorganic prebiotic soup over billions of years. These compounds came together by chance to form a complex life form capable of reproducing itself, and all this at exactly the right temperature and time.

The basic requirement of any life form is that it is able to reproduce itself. The only substance that can do this is DNA. DNA is like a very long twisted rope ladder with billions of rungs. Each rung is made up of a pair of only four nucleic bases thymine (formula $C_5H_6N_2O_2$), cytosine, guanine and adenine. These pairs are attached each side to alternating units of phosphate and deoxyribose sugar ($C_5H_{10}O_4$). A gene consists of thousands of these rungs and it is the precise sequence of the base units that makes up its specificity. For example one gene is the pattern for one polypeptide chain and the combination of different polypeptides makes a specific protein or enzyme. DNA works in a similar manner to a computer using a quaternary instead of a binary code.

The protein Haemoglobin consists of 19 different amino acids, 574 in total. If just one of these is out of place then it will not function. It has been estimated that the odds against this protein being formed by chance is 10^{500}. Bearing in mind that the number of atoms in the universe is about 10^{66}, the random formation of haemoglobin is a very unlikely event.

Every one of the 60 trillion cells in the human body contains enough DNA information to reproduce another complete human being or clone. Stem cells form themselves into multiple organs of exactly the right size. The control for this sequence of events is too complex to be understood.

If the lengths of the DNA of a single cell were put end to end it would stretch about 2 metres. Or by comparison, if the cell were the size of a soccer ball it would stretch 200 kilometres.

This entire length is kept tidy in the cell nucleus by being wound around histones. When the cell divides, and 60 billion do so in our bodies every minute, the DNA ladder splits down the middle under the influence of the enzyme DNA polymerase, (where did this come from in the original DNA Molecule?), at the rate of about 8,000 rpm (the DNA is coiled into a helix). Each strand then attracts new molecules to reform a complete helix with the help of another enzyme DNA Ligase.

It is estimated (Professor Ashley Montagu), that if the DNA from a single cell of every individual on the earth today were put together it would occupy a space no larger than a single aspirin tablet. The simplest form of DNA complex is a virus but for a virus to reproduce it needs to enter a living cell to utilise energy from mitochondria and the protein producing ability of the host cell, it is unable to reproduce on its own.

There is a complex mechanism within the DNA of every cell that corrects mutations. The genes of fruit flies were manipulated to produce flies with no eyes. When these were interbred their offspring also had no eyes. But after several generations eyes started to reappear due to this fail-safe mechanism, reverting back to a normal fly.

Dr Francis Crick, an atheist and co-discoverer of the structure of DNA admitted that it was impossible for DNA to have been spontaneously developed, he proposed that it must have come from outer space, (which in a sense it did).

Charles Darwin in his latter years wrote: "Why, if species have descended from other species by fine graduations, do we not everywhere see innumerable transitional forms? Why is not all nature in confusion, instead of the species being, as we see them, well defined? But, as by this theory innumerable transitional forms must have existed, why do we not find them embedded in countless numbers in the crust of the earth…… I have asked myself whether I may not have devoted my life to a fantasy….. I am ready to cry with vexation at my blindness and presumption……If it could be demonstrated that any complex organism existed which could not possibly have been formed by numerous, successive, slight modifications, my theory would absolutely break down."

Lastly to quote the NLT Bible, Romans 1:19, 20 "They know the truth about God because he has made it obvious to them. For ever since the world was created, people have seen the earth and the sky. Through everything God made, they can clearly see His invisible qualities, His eternal power and divine nature and so they have no excuse for not knowing God.

Bibliography

Doubleday & Co Inc, 1978, World Book Encyclopaedia

Mitchell Beazley, Encyclopaedias Limited, 1977, The Joy of Knowledge Encyclopaedia

Dr Chuck Missler, Koinonia House, 2004, Cosmic Codes

Grant. R. Jeffrey, Waterbrook Press, 2009, Creation

DAMNED IF YOU DO AND DAMNED IF YOU DON'T

Dr Mal Mohanlal

There is a lesson to be learnt for all doctors in our society, whether they are local or overseas trained, from the recent trial of Dr Jayant Patel who was found guilty of criminal negligence in the treatment of some of his patients.

I am sure Dr Patel never intended to harm or kill his patients. But because of his super ego, he overestimated his skills and is now paying the penalty for his error of judgement.

Since the medical profession is full of do-gooders with strong egos who want to save lives, it might be in their own interest to learn about the herd mentality of the public and try not to be such do-gooders.

In this consumer society where the legal system is oriented towards compensating victims by giving them money, there always will be a case of damned if you do and damned if you don't for the medical profession. One has to find the accused guilty before any compensation can be paid to the victims. So Dr Patel was a dead man walking the moment he was arrested.

Here is a case of how a smart doctor operates. In a small city a seven year old little girl is involved in a truck accident and injures her leg. She is taken to the local hospital where a fully qualified experienced surgeon sees her. He realises that this little girl is going to lose her leg and he could operate on her. But knowing the mentality of the public, he suggests that she be transferred to another bigger nearby city provincial hospital where of course they amputate her leg.

To this day the father of the girl has been heard to say "Those butchers took off my little girl's leg".

Now this smart surgeon had practically 100% success rate and everyone thought so highly of him. Experts will always say that you should not have done it. They have great hindsight, which is why we call them experts.

Food for thought for society and the medical profession!

9 July 2010

"DELUSION"

Dr Andrew Houston

Richard Dawkins in the preface to The God Delusion writes of how psychiatrists tried to persuade him not to use the word Delusion since it was a technical word. Happily he ignored them and the result is a wonderful title. For The God Delusion means literally The God from Play - a key insight.

Etymology of Delusion

The word delusion derives from the Latin *de* meaning from and *ludere* meaning to play. If you are playing and don't know that you are playing, then that is delusion. If you are playing and think that it is real, then that is also delusion.

According to the Historical Thesaurus of the Oxford English Dictionary (2009) the words delude and delusion date from around 1420 when they were used in the sense of "To Play False". If I play you false then I seek through my words and acts to delude you into thinking that what I say and do are true and real. The word delude was used in the transitive sense of I delude you. I seek to pretend to you, to mislead, deceive, misinform, betray, and cause you to believe falsely, hence delusion.

Delusion was first used in the sense of madness, in 1552. Delude is used in the KJV of the Bible and in Shakespeare and always in the sense of betray or misinform causing a false belief.

Psychiatry and Delusion

This was the case till more modern times when psychiatry tried to hijack the word delusion for its own ends. It is unclear when the modern technical use of the word delusion occurred. The words "psychiatry" first appeared in 1846 and "schizophrenia" in 1912. Psychiatry defines delusion as "*A false personal belief that is not subject to reason or contradictory evidence and is not explained by a person's usual* ***cultural and religious concepts"***. It is those last two items that obscure the diagnosis.

That culture and religion are delusional, because they are based on play, was demonstrated in 1938, by Johan Huizinga, the Dutch cultural historian, in his classic 'Homo Ludens' (Playing Man) 'A Study of the Play-Element In Culture'.

Culture and religion are both delusional systems, even though they are considered normative within any culture. Psychiatry seeks to exclude culture and religion from its definition of delusion even though both are delusional systems in the sense that they are based on playing falsely.

Religion as a Competitive Game.

Browse the Internet and you will find many articles likening sport to religion. They all miss the point however, which is that religion is like sport. In fact religion is not just *like* sport; religion is a sport, a competitive game and the fact that it is not recognised as such, is where the delusion comes in. Consider that music, choral singing, laughter, nativity scenes, myths, doll-like statues, imaginary friends, becoming and misattribution is all part of the religious experience and that they all have play elements. It becomes clear that religion consists of a series of play phenomena which are experienced as if they were real.

Peter Gray, a psychologist, has written beautifully along these lines, although he considers that competition is play which has been corrupted. He approaches religion as play, from an anthropological perspective using primitive hunter-gatherer groups as his model and he makes some wonderful points:
"The essence of all religion is faith. To have faith is to believe without evidence. To believe without evidence is to make believe. To make believe is to play."

"Fun, beauty, creativity, representation, imagination--these are the essences of art, music, literature, theoretical science, and religion. These activities, which characterize our species everywhere, make us human. They all originated biologically in play. Play is the biological germ, which we inherited from our animal ancestors, which grew in us to make us human."

"I have two main points to make. The first is that all of religion has its roots in play. The cognitive skills that make religion possible are the skills of play, the most central of which is make-believe. The second point is that religion functions best when it does not stray too far from its playful origins. Religion that has lost its playfulness can be dangerous."

"The truths of play are true as long and only as long as the play continues. When play is over, or during time out, Suzie and Jimmy may say that they were only pretending to be a witch and a troll; but they would never say that during play. In fact, it would be impossible for them to say that during play, because the very act of saying it automatically stops the play and creates a time out. Religion, for the devout, has no recognized time out; so the devotees may have no opportunity to say that their religious beliefs are make-believe, even if at some level of consciousness they know that that this is so."
"Hunter-gatherer parents do not become upset

when their children marry into another group and adopt religious beliefs and practices that differ from those they grew up with. To leave one band and join another, with different religious practices, is in this sense like leaving a group who are playing one game and joining another who are playing a different game. There seems to be an implicit acknowledgment, among these people, that religious stories, while in some ways special and even sacred, are in the end just stories."

"Religion, properly conceived, is a grand and potentially life-long game in which people use the basic structures of the game, story outlines, beliefs, and rituals along with their own creative additions and modifications, to make sense of their real world and real lives. The stories and beliefs may be understood as fictions, but they are sacred fictions because they represent ideas and principles that are crucial to living in the real world and they may be held through all of life.

It is not surprising, from this view, that religious stories and beliefs everywhere reflect and elaborate on ideas and themes that are crucial to the society in which the devotees live their real lives. Hunter-gatherers depend on principles of equality and sharing, and so it is natural that their deities are not rulers but equals, who contribute and sometimes fail to contribute, as they will.

Hunter-gatherers also depend, every day, on the whims of nature, which they cannot control, so it is not surprising that their deities are whimsical. The best way to deal with unpredictability is through humility and humor, and their religions foster those traits. Their task is to embrace nature, not to control it, and their religious play with the spirits of the natural world help them to do that.

With agriculture, religion changed. Agriculturalists attempt to control nature, and so the gods of agriculture are controlling gods. With agriculture, and with the land ownership and accumulation of wealth that accompanies it, egalitarianism lost its sway and concepts of lords and masters, and of servants and slaves, emerged. It is not surprising, then, that hierarchical concepts of the spirit world emerged in post-agricultural religions peaking in the Middle Ages, in the dominant monotheistic religions, Islam and Christianity. At a time when most people were servants, it was only natural that religious stories and beliefs would focus on the value of servitude and duty to lord and master, and that God would be understood as the supreme master, the king of kings, lord of lords. Such beliefs gave meaning to a life of servitude and helped the rulers to justify their power."
"If children playing that they are witches and trolls did not know that they were just pretending, we would worry. We know, for children, that failure to distinguish imagination from reality can be dangerous. We should know that this is even truer in the case of adults and religion."

Notes
The Historical Thesaurus of the Oxford English Dictionary (2009) is available online at the University of Glasgow:
• http://libra.englang.arts.gla.ac.uk/historicalthesaurus/

Peter Gray's essays on play may be found at
• http://www.psychologytoday.com/print/5051 I
• http://www.psychologytoday.com/print/5238 II
• http://www.psychologytoday.com/print/30066 III
• http://www.psychologytoday.com/print/30309 IV
• http://www.psychologytoday.com/print/30523 V
• http://www.psychologytoday.com/print/30743 VI

My own musings can be found starting at page 8 on my home page and take it from there.
• http://ahouston.customer.netspace.net.au/Site/Page_8.html
• http://ahouston.customer.netspace.net.au/Site/Welcome.html

MEDICAL MOTORING

with Doctor Clive Fraser

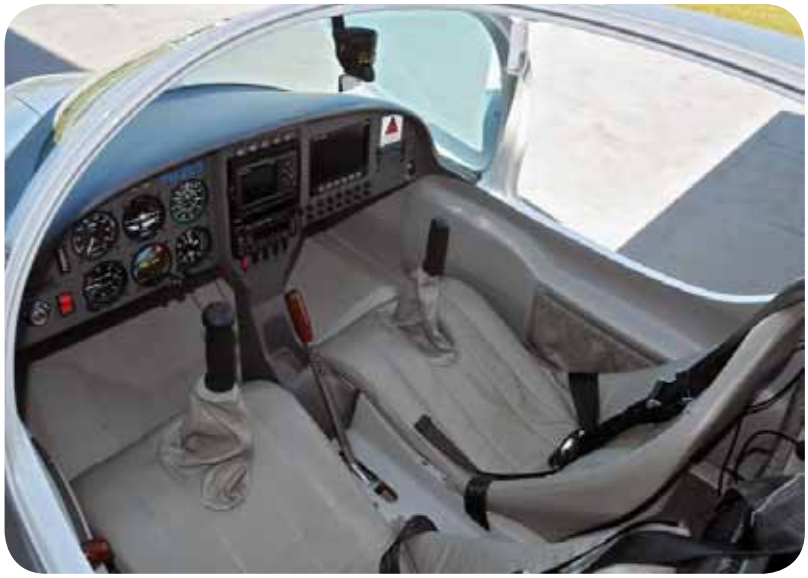
Motoring Article #73

Super Petrel – Amphibious Plane

I'd always thought that super petrol was something that you put in your fuel tank.

So when a colleague told me he was going to buy a "Super Petrel" I looked at him dumbfounded.

He scornfully said, "Don't you know anything about planes?" which was true and proceeded to tell me that the Super Petrel is a new type of amphibious aircraft that's made in Brazil.



Designed to land on any stretch of water this could be just the transport for flying doctors, and with a retractable under-carriage bush runways are also no problem.

With a body made of composites (carbon fiber, Kevlar and fiber-glass) and with an enclosed cockpit the Super Petrel is certainly an up-market offering in the ultra-light segment.

First impressions were that it is a surprisingly stylish thing with a silhouette reminiscent of a Catalina flying boat.

The hull is constructed with a configuration which relies on boating principles meaning that the Super Petrel reaches planing speed quickly and the lower wings deflect spray away from the propeller.

Powered by a dependable Rotax 100 Hp motor it will take-off in only 80 meters on land and 40 meters more in the sink.

On the return run it will land in only 120 meters on the bitumen and 20 meters less in the water. Once up in the air there are some comfort options like a cock-pit heater, but the basic model comes in at only 320 kg and other specified options will cut into the 280 kg pay-load.

The standard propeller can vary the pitch before take-off for fine-tuning dependent on the load.
In the unlikely event of a catastrophic failure there is a ballistic parachute option available for $10,000.

The distributor told me that most buyers won't be likely to take up this option as with a slow stall speed you're always better off looking for somewhere to land safely rather than pulling the parachute's pin and taking a hard landing in the seated position.

The Super Petrel can be flown without a General Aviation pilot's licence, but you will need a pilot's certificate which involves about 20 hours of training.

The pilot's certificate also qualifies you to service your own plane.

You'll need to follow VFR (visual flight rules), stay within 25 nautical miles of your point of departure and stay out of controlled air space.

With endorsements you can go cross country and land on water.

But don't forget that once you're in the drink you'll need a boat licence as the plane legally becomes a boat at that point.

EDRA Aeronautica - Super Petrel LS

For:	Affordable, go anywhere.
Against:	Not everyone wants to be able to land on water.

This plane would suit: Flying doctors.

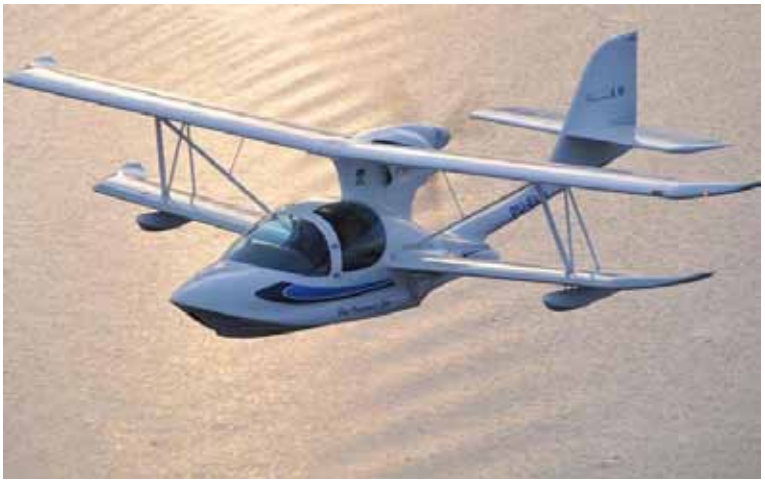
Specifications:

- Rotax 1352cc 4 cylinder 4 stroke boxer
- Air-cooled cylinders, water-cooled heads
- PULP or Avgas 100 LL
- 100 hp (75 kW) @ 5800 rpm
- 128 Nm @ 5100 rpm
- Cruising speed 180 km/h
- Stall speed 56 km/h
- 18 litres per hour in flight
- 4.5 flying hours
- Range 740 km
- Empty weight 320 kg
- Maximum take-off weight 600 kg
- $115,000 ready to fly
- $200 for a 100 hour engine service (oil and filter change)
- RAA pilots are authorized to do their own maintenance
- Made in Brazil

Safe flying,

Doctor Clive Fraser

doctorclivefraser@hotmail.com.



MORETON BAY GENERAL PRACTICE NETWORK
CHIEF EXECUTIVE OFFICER
Paul Sutton

Political and public attention is strongly focused on improvement in Health Care. There is no better time to ensure the voice of our Primary Care sector is strong and clear. The future health of our community rests on a well connected health system. The Moreton Bay General Practice Network has a key role to ensure this happens. This is our future – working in partnership with our General Practices and other community groups to ensure our community receives best practice care.

The Moreton Bay General Practice Network continues to work closely with General Practice, allied health, individuals and community groups to build a network of linked and coordinated services and support structures. By increasing the effective reach across the community encourages collaborations and linkages between health services to support patients.

Our network allows the most effective achievement of our goals and the programs required to deliver them. The following pages will highlight these goals, programs and the support structure that the Moreton Bay General Practice Network provides to general practice and community groups. We are preparing our local General Practices and community for the future.

Creating great connections throughout the community ensures the most effective way to achieve our goals. In order to meet these ambitious goals we are constantly seeking excellence in all areas and maintaining our strong belief in evidence-based interventions.

There are many ways to become involved. Membership is the obvious one. By becoming a member you will have a voice on the future of our Primary Care system. You may wish to help us to deliver some of our programs or help by fund raising. This will help to ensure the Moreton Bay General Practice Network is able to continue its independent work with the freedom that has already set it as a centre of excellence and helped influence national directions.

As health professionals your ability to influence national discussion and direction is greatly enhanced by a strong Moreton Bay General Practice Network. By simply registering as a member within the Moreton Bay General Practice Network you are adding your voice to those of your fellow professionals. The level of your involvement from there is only limited by your vocational passion for the best Primary Care system possible.

Thank you for your support and encouragement throughout 2009-2010!

Paul Sutton
Chief Executive Officer

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION INC
PRESIDENT'S COLUMN
Dr Wayne Herdy.

By the time this is read, the Federal election will have come and gone. As I write, the outcome still rests on a knife-edge, and I am not going to attempt to guess which colour government will be deciding medical politics for the next three years.

Health has been a low-profile issue in the election campaign. Most health policies on offer were around changes in general practice. The local highlight was the announcement of a potential GP Superclinic for Caboolture. GP Superclinics were from the outset controversial at best. The GPSC concept is creative but flawed. The positive benefit being offered was the potential for patients to gain ready access to a wider range of health resources, especially allied health personnel for patients with chronic and complex disease.

Established GP's were troubled by the enormous economic kickstarts being given to competitors. As well as the creation of a non-level playing field, there was the risk of short- and long-term disadvantage to established practitioners, and the assumption that any new organization that needs such a large establishment fund might not be sustainable in the long term. In my view, history discloses that of the original wave of 30 GPSC's only two came into existence, so it was illogical to propose another 29 to augment a policy that had already demonstrated failure. Finally, even the most diplomatic response from the AMA said that it was difficult to find any explanation for the sites of GPSC's other than noting that they were all in marginal electorates.

The other local issue that achieved some prominence was the promise to fund the long-awaited rail link to the Redcliffe Peninsula. Although transport is generally a State issue, and this proposal has been raised in every State election for 20 years, big public transport infrastructure projects can be nationally important. The Redcliffe rail link is not quite on the scale of the Ghan railway line from Adelaide to Darwin, but it was refreshing to see something that looked like a real local change getting genuine traction at long last. Even if it has no real medical significance.

The next meeting of RDAMA is to be held on Wednesday 25th August. It is our Annual General meeting.

The AGM has to be held to complete some functions that are required by law, including presenting our financial figures to the membership and appointing an auditor. Not pulse-raising stuff, but necessary.

Another function is the election of the four members of the executive, the people who keep the organization running and decide its direction. All positions are declared vacant, and all members are invited to take a more active role in determining the direction of YOUR Association.

During my Presidency, I have worked to improve our Association in two ways. Firstly, with the approval of the membership, I have given direction for our newsletter publisher to produce a genuinely local newsletter. Secondly, I have worked to develop a branch in Caboolture. Although we technically cover the geographic area including Burpengary, Morayfield, Caboolture and even Bribie and Kilcoy, as long as we have our monthly meetings at Redcliffe we are offering few services to the members of the northern section of our territory.

We have held inaugural meetings of the Caboolture branch of RDAMA. They were poorly attended. We will be arranging only two more meetings. LMA's are a unique opportunity for networking, combining educational and social activities, and a forum for hearing and discussing political issues. If the attendance response remains poor, we will arrange no more Caboolture meetings.

If this is something that our northern members (and potential members) want, then they will have to support the meetings. Otherwise it will be a long time before any future President goes to the effort and takes the risks involved in trying to establish a monthly forum for local doctors in that area.

Wayne Herdy,
President,
Redcliffe and Districts Local Medical Association.

AMAQ & FEDERAL COUNCILLOR REPORT - *Federal Election*

Wayne Herdy, North Coast area representative, AMAQ Branch Council, Queensland area representative, AMA Federal Council.

In the early days of the election campaign, the AMA released its election manifesto. That wishlist was based on 14 domains, ranging from the dominance of GP issues, health funding and public hospitals, to e-health and climate change. The details of the AMA policies and outlining issues for doctors, the public, and the parties were published on the AMA website. We did not want to publish a comparison of the offers from both major parties and our policies. What was obvious early in the campaign was that, from the beginning, the AMA had a clear message and stuck to that message, whereas both parties kept offering tentative incremental policies which were no more than a public auction for votes.

Neither party was prepared to take the chance of making promises that stood out as attractive or unattractive to the profession or to consumers. The only truly significant difference was that the coalition was prepared to shelve e-health initiatives. While that might have been in keeping with their refusal to proceed with the national broadband project, the issues were different. Whereas it is arguable that the national broadband scheme was unaffordable, there is no sense in the health environment that delays to progressing and implementing e-health was either unaffordable or undesirable. Contrarily there is a strong desire in most doctors to have e-health on their desktops as soon as possible.

The underlying difference between the two parties is best understood in terms of their reform agendas. One party took the stance that health care in Australia is fundamentally sound but needs some adjustment in funding and fine-tuning of the structure. Another party took the view that healthcare in Australia is fundamentally flawed and needs major structural reform. One strategy is low-risk but incurs the risk that we will not see different health outcomes. The other strategy ran the risk of unpredictable, unforeseen consequences, and unknown final effects on health outcomes, but had the potential to produce significant long-term changes which would hopefully be for the better – for patients at least.

AGED CARE

Federal AMA used to have a Committee for Care of Older People, later renamed Committee for Healthy Ageing. That committee was dissolved a year ago because it was thought that aged care could be adequately discussed within another committee. This year, that decision was reviewed – the aged care discussion proved too large a workload to be absorbed within another committee and some felt that the content of its discussion was too specialized to be adopted by a less dedicated committee. The Committee for Healthy Ageing has been reconstituted, and I am honoured and pleased to have been appointed its Chair. Even before its first meeting, the Committee was called on to make a submission to a Productivity Commission enquiry into aged care. Such an early call on its expertise by such an important enquiry illustrates just how vital this growth health area is that AMA has a committee dedicated to it.

MEMBERSHIP

All membership organizations need to constantly review their membership – recruiting new members, and retaining all members which means offering value for money and the services that are actually wanted by both long-term and newly-joined members. What comes across clearly is that AMA members and non-members want the AMA to give them a national voice, to do what the AMA does best and that is to develop policy and be an effective lobbying group at national and State levels.

The AMA faces a few particular problems with membership, especially the “free rider” problem. Every doctor in Australia benefits from the activities of the AMA – we have a saying that every doctor in Australia is an AMA member, there are just some who don’t pay their subscriptions.

The AMA needs to recruit non-members as members, not only for the subscription revenue, but to give us power. There is strength in numbers. As the AMA membership reaches a higher percentage of the overall doctor population, we have increased credibility when negotiating with government, but we also have more bargaining power when negotiating with big business, getting better deals on member benefits such as credit card deals. Our activity during the now-forgotten indemnity crisis of only a few years ago saved every doctor in Australia a sum of money that more than pays for their annual subscription – for the rest of their practicing lives. Our financial deals with other businesses can potentially save more than the price of membership. And that is without all the professional services that accrue to every member. For most members, our core business of being a political lobby group comes as a free bonus. Probably few non-members have read very far into this paragraph, but the AMA members who have read this far should be prompted to urge their non-member colleagues to join up, and share the financial load of getting the benefits that the AMA wins for Australian doctors.

Interesting Tidbits

NATTY MOMENTS:

I have not checked out whether they are accurate but thought I would share these with you and let you form your own opinion!

1. It is physically impossible for pigs to look up to the sky.
2. A polar bear's skin is black. It's fur is not actually white, but clear.
3. More people are killed annually by donkeys than die in air crashes.
4. You burn more calories sleeping than watching television.
5. 35% of people who use Personal ads for dating are already married.
6. Leonardo da Vinci invented scissors.
7. Lemons contain more sugar than strawberries.
8. Boanthropy is a disease in which a person thinks they are an ox.
9. Babies are born without kneecaps. They do not appear until the child is about 2 – 6 years of age.
10. Because of the rotation of the earth, an object can be thrown further if it is thrown West.
11. The average human body contains enough fat to make seven bars of soap.
12. The strongest muscle in the body is the tongue.
13. People say 'Bless you' when you sneeze because when you sneeze, your heart stops for a millisecond.
14. In the course of an average lifetime you will, while sleeping eat 70 assorted insects and 10 spiders.
15. The pupil of an eye expands as much as 45% when a person looks at something pleasing.
16. An ostrich's eye is bigger than its brain.
17. By law, every child in Belgium must take harmonica lessons in primary school.
18. While performing her duties as Queen, Cleopatra sometimes wore a fake beard.
19. Did you know that you share your birthday with at least 9 million other people in the world?
20. The shortest war in history was between Zanzibar and England. Zanzibar surrendered after only 38 minutes.

Viewed website 16/08/10 http://homeschoolblogger.com/ausnat/89496/

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PSA TESTING UPDATE FOR GENERAL PRACTITIONERS

UPDATED UROLOGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND PSA GUIDELINES

Recently the Urological Society of Australia and New Zealand released a policy statement on PSA testing. In essence the policy states that a single initial PSA test combined with a DRE should be offered to all men from the age of 40 after an informed discussion of the risks and benefits of PSA testing. In men aged 75-80 yrs, screening should be considered on an individual basis. The USANZ policy along with a detailed analysis of the relevant literature can be accessed via my website http://www.troygianduzzo.com.au under the tab "Prostate News" located on the bottom right corner of the home page.

In essence, the aim of this policy is to risk stratify patients into high risk or low risk for the subsequent development of prostate cancer by comparing a patient's PSA to the median PSA for his age. An initial PSA test should be offered to all men at the age of 40 after an informed discussion of the pros and cons of PSA testing. Patients who have a PSA higher than the median for their age (PSA > 0.6 ng/mL, age 40-49 yrs; PSA > 0.7 ng/mL, age 50-59 yrs) are at a higher risk for the subsequent development of prostate cancer and should be followed more closely with annual PSA and DRE. Conversely patients with a PSA value less than the median could be followed less frequently. It is important to note that a PSA above the median does not mean that the patient necessarily needs a biopsy. Rather it is a risk stratification tool to identify patients who should be followed more closely.

Patients with a significant rise in PSA levels (>0.35/yr for values <4.0 and >0.75 /yr for values >4.) should be considered for TRUS biopsy. In addition men with a low free:total PSA ratio should also be carefully considered. Men with a positive family history of prostate cancer should be offered annual screening with PSA and DRE irrespective of their PSA value. It is vitally important that PSA testing is combined with a DRE as a "normal" PSA value does not exclude prostate cancer. A patient with an abnormal DRE should be referred for consideration of a TRUS biopsy irrespective of the PSA level.

DOES PSA TESTING DECREASE PROSTATE CANCER MORTALITY?

Two trials published in the March 26, 2009 edition of the New England Journal of Medicine addressed whether PSA screening decreases prostate cancer mortality.

Andriole et al published the first report on prostate cancer mortality from the from the PLCO (Prostate, Lung, Colorectal and Ovarian) Cancer screening Trial.[1] In this report, 76 693 men aged 55-74 years were randomly allocated to screening or usual care. The study concluded that there was no significant difference in prostate cancer mortality between the 2 groups with 50 deaths in the screening group at 7 years and 44 in the control group.

However this study has been criticised heavily because of significant contamination in the control group in which 52% of the controls had received PSA testing by the 6th year. In addition 44.1% of patients in the control group had at least 1 PSA test at baseline and 53.9% of controls had a prior DRE.

The European Randomised Study of Screening for Prostate Cancer (ERSPC) reported on 182 160 men aged 50-74 from seven European countries who were randomised to screening or no screening.[2] There were 214 cancer related deaths in the screening group and 326 deaths in the control group. After correction for non-compliance, there was a reduction in the detection of advanced disease and a 27% reduction in the risk of death from prostate cancer. In this report, the survival curves began to separate at 7 years suggesting that longer follow-up may show a more marked difference. The number needed to treat to save one life in this trial was 48 while the number needed to screen was 1410 indicating a potential overtreatment effect. However follow-up was relatively short with a median of 9 years and it is possible that the differences between the groups may become more marked over time. Indeed at the National Prostate Cancer Symposium just held in Melbourne (August 11-13, 2010), Dr Pim van Leeuwen of the Department of Urology, Erasmus University Medical Centre, Rotterdam, The Netherlands presented yet to be published updated figures of the ERSPC data with further follow-up to 12 years demonstrating a further separation of the curves and a further reduction in the number needed to treat.

The number needed to screen in the published 2009 ERSPC study is similar to that seen in breast cancer screening studies. In a recent meta-analysis of breast cancer screening for the U.S. Preventive Services Task Force the number needed to screen to prevent one breast cancer death was 1904 (95%CI: 929-6378) for women aged 39-49 years, 1339 (95% CI: 322-7545) for ages 50-59, and 377 (95%CI: 230-1050) for ages 60-69.[3] It is also interesting to note that in Australia in 2006 there were 17,444 prostate cancers diagnosed and 2,952 deaths representing 29% and 13% of all non-cutaneous

cancers in men respectively. The mortality to incidence ratio was 0.19. For breast cancer in that same year there were 12,614 diagnoses and 2,618 deaths representing 28% and 15% of all non-cutaneous cancers in women with a ratio of 0.20.[4]

Another notable study is The Tyrol Prostate Cancer Demonstration Project.[5] This study evaluated the prostate cancer mortality rates in the state of Tyrol in Austria, where PSA testing is widely available free of charge, in comparison to the rest of Austria where PSA testing was not freely available. Thus it compared a screened population to an unscreened population in the same country. Prostate cancer deaths in Tyrol in 2005 were 54% lower than expected compared to a 29% reduction in the rest of Austria which represented a 25% improvement.

DOES PSA TESTING LEAD TO OVERTREATMENT?

These and other studies suggest that PSA testing and prostate cancer treatment do decrease the risk of prostate cancer mortality. However there is some concern regarding the overtreatment of clinically insignificant disease. In response to this, active surveillance is gaining acceptance as an alternative strategy in select patients.

Patients diagnosed with low volume, low grade disease may indeed have indolent disease and such patients may be candidates for an active surveillance protocol. The aim of this approach is to monitor a patient who appears to have an indolent cancer and then institute active primary treatment such as radical prostatectomy, radiotherapy or brachytherapy with curative intent if or when the cancer becomes clinically significant. This approach is distinctly different from "watchful waiting" in which delayed palliative hormonal manipulation is utilised in men with a limited life-expectancy because of age or co-morbidities. A number of active surveillance protocols have been proposed but in essence each approach involves regular PSA monitoring every 3-6 months, regular DRE every 6-12 months and interval TRUS prostate biopsies. Should the cancer be upstaged or upgraded the patient can then be offered active primary treatment at that point. I personally also perform an early repeat prostate biopsy within 3 months of the initial biopsy to ensure from the outset that the first biopsy did not falsely understage the tumour.

The advantage of active surveillance is that it avoids overtreatment of a potentially clinically insignificant tumour. In addition it may allow the patient to gain an extra few years in which their quality of life is maintained without incurring treatment side-effects before active treatment is required. Disadvantages of this strategy include possible understaging the initial tumour, potential missed opportunity for cure and the possible need for more aggressive treatment when it is required such as the need to perform a non-nerve-sparing prostatectomy when a nerve-sparing procedure could have been performed at the outset.

WHEN TO REFER

Patients aged 40-75 with an abnormal PSA, an abnormal DRE, a normal but rapidly rising PSA or a low free:total PSA ratio should be referred for assessment. It is important to note that a 'normal' PSA does not necessarily exclude prostate cancer. Patients >75yo should be assessed individually in context of their co-morbidities and overall life expectancy.

WHEN TO REFER

- Abnormal age-adjusted PSA
- Rapid rise in PSA even though PSA may be "normal". (rise in PSA > 0.35 / yr for total PSA values <4 and >0.75 /yr for values 4-10)
- Low percentage free:total PSA <11%
- Abnormal DRE

URGENT CONTACT

If you have any questions at any time, please do not hesitate to call me directly on my mobile on 0437217011. I am more than happy to receive such calls.

ABOUT TROY GIANDUZZO

Dr Troy Gianduzzo is a Urologist who specialises in prostate cancer care and offers patients robotic-assisted radical prostatectomy, pure laparoscopic radical prostatectomy, low-dose rate and high dose rate brachytherapy and a range of other options depending on their clinical needs. He is the only internationally trained Brisbane urologist to offer both robotic and pure laparoscopic radical prostatectomy. Dr Gianduzzo undertook fellowship training in the UK and also the Cleveland Clinic, USA and was the first fellowship-trained Urologist to offer minimally-invasive radical prostatectomy in Queensland. He has an active research interest with over 50 peer-reviewed abstracts and publications and has been the recipient of several state, national and international awards for research and is currently completing a masters of surgery through the University of Queensland on advances in robotic radical prostatectomy. His CV can be viewed on his practice website http://www.troygianduzzo.com.au.

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MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA welcomes today's commitment from Labor that, if elected, it would invest heavily in telemedicine to support and enhance health services as a part of a modern health system. AMA President, Dr Andrew Pesce, said the investment would assist doctors to better use communications technology to provide services to patients who would otherwise have limited or no access to these services.

This is a recognition of the need to embrace communications technology to modernise our health system," Dr Pesce said. "It will allow doctors to overcome the tyranny of distance when providing care and advice for patients in rural and remote Australia. Some patients will no longer have to travel long hours and incur significant costs to access medical care.

"Ongoing support for telemedicine services, through Medicare patient rebates and support for IT infrastructure and training, will ensure that local doctors can obtain specialist input for the ongoing care and management of their patients. "The capacity to download test results and high quality diagnostic images quickly will enhance the care that local doctors can provide via telemedicine networks, including the use of high quality video for doctor-patient consultations and videoconferencing.

"As the take-up and reach of telemedicine technology and services grow, so too must the investment to ensure that the telemedicine networks stay modern and new technologies are introduced as they become available.

"There would need to be close consultation with the AMA and the medical profession, especially rural doctors, to ensure that these initiatives provide the maximum benefit to patients and communities. The AMA would also like to see a corresponding commitment to attracting and retaining doctors in rural and remote communities to complement these important measures."

The AMA Position Statement on On-Line and Other Broadband Connected Medical Consultations recommends that telecommunications consultations should:

- only be used as an adjunct to normal medical practice, and incorporate the ultimate right of the doctor to determine whether or not he/she will provide any medical care to any patient on- line;
- only replace services where the quality and safety of patient care is not compromised, including where they provide access to medical care services in areas where such services are otherwise unavailable;
- not replace face-to-face consultations where the provision of quality care requires a face-to-face consultation; and
- incorporate the ultimate right of the doctor to determine whether consultation or provision of specific advice or care on-line is appropriate in any circumstance.

16 August 2010

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CHANGES TO CLASSIFIEDS

Classifieds remain **FREE** for current members.To place a classified please email: RDMAnews@gmail.com with the details for further processing.

Classifieds will be published for a maximum of three placements.

Classifieds are not to be used as advertisements.

Members wishing to advertise are encouraged to take advantage of the Business Card or larger sized advertisement with the appropriate discount on offers.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION MEMBERSHIP

Attendance at the Redcliffe & District Medical Association (RDMA) Meeting is **FREE** to current RDMA members.

Doctors are welcome to join on the night and be introduced to the members. **Membership application forms are in this edition and available at the sign-in table on the night.**

Meeting dates are in the date claimers on page 4
COST for non-members:

- $30 for doctor, non-member

The RDMA has Public Liability Insurance

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription due for the period: 1st July 2010 to 30th June 2011

Dear Doctor

The Redcliffe and District Medical Association Inc. has had another successful year of interesting and educative meetings on a wide variety of medical topics. It's now time to show your support for your Local Medical Association to continue the only local convocation for general practitioners and specialists to socialize and to discuss local and national medico-political issues.

As this is now June 2010 your subscription to cover until the 30th June 2011 will be $100. Doctors-in-training and retired doctors are invited to join at no cost. This subscription not only entitles you to twenty (20) dinner meetings but also to a monthly RDMA Newsletter. Suggestions on topics and/ or speakers are very welcome.

Please can you endeavour to pay your subs by internet banking as it is so much easier for all concerned as it saves you writing cheques and us having to bank them. You will receive your receipt by email if you supply your email address to me on GJS2@Narangba-Medical.com.au.

Yours sincerely

Dr Peter Stephenson
Treasurer

ABN 88 637 858 491

Note: Two Medical Practitioners from the One Family Qualify for a $25 Discount each

Dr. _____ _____
(First Name) **(Surname)**

EMAIL ADDRESS: _____

Practice Address: _____ **P/Code:** _____

Phone: _____ **Fax:** _____

1 Member ($100) 2 Family Members ($150) (Please supply details for both members)

Doctors-in-training and retired doctors: free

PREFERABLY Paid by: **Internet Banking (don't forget to put your name on the deposit i.e: Dr. F. Bloggs RDMA)** A/c BSB 064 122 Acct. No.: 0090 2422 Redcliffe and District Medical Assoc. **DATE & BANK Paid**

Enclosed payment

Please complete this form and return to: Redcliffe & District Medical Association Inc. P O Box 223 Redcliffe 4020

OR c/-QML or by email to GJS2@Narangba-Medical.com.au

Cont frontpage: **Sarah & Carolin's First day in Australia.**

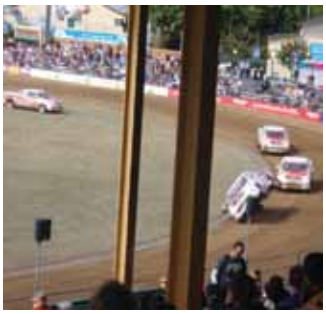
Honestly, we had no previous idea of what Caboolture had to offer. We only knew that it is a suburb of Brisbane and you search to no avail for its location in the guidebook. We were allured by the beautiful landscape and the mild winter so we choose Brisbane for our elective period.

The sun did not disappoint us. It awaked us after a long flight of more than 24 hours and a very short night. Let's discover our new temporary home country! We benefited from the RNA public holiday and became a part of the spectacle. The exhibition was a real adventure: it was a colourful mixture, between an amusement park and a trade fair. We saw children's eyes which shined because of all the carousels. We got to know about "showbags". We sensed the agricultural side of Brisbane. We patted new born birdies.

We were especially electrified and fascinated by the stream of thousands of people who came to the show. After this amazing day, we spent the evening in Brisbane to indulge ourselves in a refreshing drink. Furthermore, we ambled along Brisbane River and in between impressive skyscrapers and sweet little houses.

To sum up, it was a great first day in "Down Under"!


Sarah and Carolin tried out the Rock Climbing Exhibit




Events in the main ring were the syncronised Toyota Hilux Heroes and cattle being prepared for judging.

We enjoyed the views of the skyscrapers on the river.


We loved the colourful Australian flowers & plants.


Sarah and Carolin ambled along the Brisbane River and took in the sight of the Story Bridge.