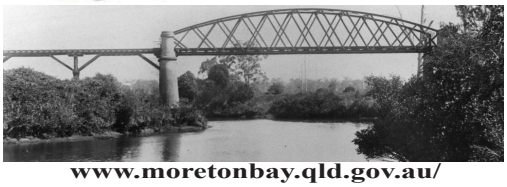
RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
DECEMBER 2013

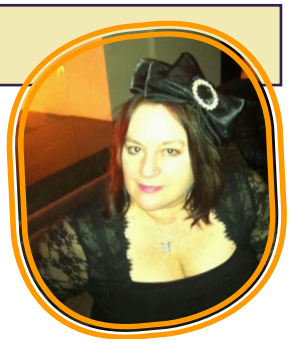


www.moretonbay.qld.gov.au/
Caboolture River & Rail Bridge

Burpengary Creek

See our historical article in our regular Where We Live And Work segments on Burpengary Creek on pages 5 & 20.

President's Message . Dr KIMBERLEY BONDESON



Seasons Greetings to Everyone. Hope you all enjoy the Christmas & New Year break and if you are working, you still manage to enjoy the day. December has been a busy month. Government organizations seem to try and "sneek" things in, so that by the time everyone is over the holiday season, which is not called the "silly season" for nothing, certain events will have been in place for a period of time and could be seen as 'fait accompli.'

Hospital Contracts Negotiations between the "team" comprising AM, ASMOFQ & Senior SMO' s and the Dept of Health representatives has managed to extend adraft contract discussions with the Health Department into 2014. Issues being address are:

- Dispute resolution
- Recognition of core duty training & education
- Clinical autonomy
- Overtime for excess hours for part-time SMO's.

Of note there is no comment on call-ins or overtime payments for VMO's. This is particularly significant, as in the UK, they have a system called "streaming" where the consultants are called upon to attend after-hours emergencies not only at their own hospital but are expected to travel to other hospitals as well. This needs to be watched carefully, as it would appear to be a much cheaper option for the hospital to call in a Specialist Consultant to treat a patient at another hospital then it is for an ambulance to transfer the patient to a tertiary center for treatment by a registrar. Consultants would therefore be working days in clinics and theatres, then being on-call, as well as their teaching and any research responsibilities. It would also take away Registrar teaching and learning opportunities. In my own hospital time, the consultants were only called into the hospital after hours when the registrars could not handle a situation.

Medicare Locals The AMA is calling on the Government to 'comprehensively overhaul' the Medicare Locals model. In my own practice, not one patient has actively been assisted by Medicare Locals. In fact, one of my patients is completely housebound and needs some sort of chair lift to be able to leave her high set home. In desperation I contacted Medicare Locals, who did an extensive review and visit to my patient. They then gave me a report, and urgently recommended a podiatrist do a home visit, and requested that I do an EPC plan. An EPC plan had already been done for this patient, which I informed the Medicare Local, and dutifully did the referral they requested. It would appear to be a very expensive podiatrist visit. The patient is still house bound, does not have any home assistance, an unsafe bathroom, toilet and kitchen, and still cannot leave the house. Now her husband is in hospital, and she does not even have anyone to do her shopping.

An Ipswich GP is extremely irate, as a fully functioning GP after hours service in his area was disbanded after his Medicare Local refused to assist them, and did not offer a replacement. Yet there has been a massive input of Government Funding into these organizations, and I have still yet to see, or hear a report of a single benefit to any patient from any of them. An investigation of monies spent by these organizations, needs accounting for, or is it a matter of another white elephant, such as the empty GP Superclinic in the Redcliffe Hospital grounds that cost around $23 million of taxpayers money? – Yes, it is still empty.

Medibank Private Health Insurance and IPN Alliance. Medibank Private Health Insurance (which is government owned and currently up for sale) have an 'arrangement' with IPN where participating GP's agree to bulk bill Medibank Private Members and be seen within 24 hours. One of my patients went to see her 'normal GP' at one of these clinics and at the end of the consultation, she signed a bulk billing Medicare form, as well as a slip for her Health Fund for payment to the doctor. I thought it was illegal to accept any other payment for a consultation after the patient had signed the bulk billing form. Now over to Dr Bob Brown, many thanks for his hard work, along with his and our own committee on this important issue.

RDMA WELCOMES
A Message From
Dr BOB BROWN,
President Northside Local Medical Association
"Managed Care, 'Sneaking in by Stealth'" **Continued on Page 3**

The Redcliffe & District Local Medical Association sincerely thanks QML Pathology for the distribution of the monthly newsletter.

2014 MEETING DATE CLAIMERS:

For all queries contact Margaret MacPherson Meeting Convener: Phone: (07) 3049 4444

CPD Points & Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Next Meeting

Tuesday February 25th
Wednesday March 26th
Tuesday April 29th
Wednesday May 28th
Tuesday June 24th
Wednesday July 31st
AGM - Tuesday August 30th
Wednesday September 18th
Tuesday October 29th
NETWORKING: Friday November 29th

CONTACTS:

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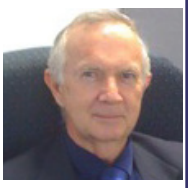
Dr Kimberley Bondeson
Ph: 3284 9777



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FEBRUARY NEWSLETTER 2013

The 15th February 2014 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com
Website: http//www.rdma.org.au

INSIDE THIS ISSUE:

NORTHSIDE LOCAL MEDICAL ASSOCIATION PRESIDENT
Dr ROBERT (BOB) BROWN

"Managed Care "Sneeking in by Stealth""

The saga of the trial by Medibank Private in Brisbane continues.

We wait to hear from GP representative bodies like the AMA and the RACGP about our concerns.

In particular, the legality of the trial as we see it.

Is a form of co-payment being contemplated on top of a direct billed Medicare service?

Is this the start of a US style managed care arrangement? Why the secrecy? Where is continuity of patient care or is it intended that only some General Practices will be seen acceptable to Medibank Private?

We need answers now!

As well as this issue, the negotiations for hospital based doctors are not as yet settled.

It is our hope that the Queensland Government recognises that our patient need the continuation of a public hospital and health system which recognises and respects the value of a skilled and happy workforce with surety of tenure and good working conditions.

On a happier note,

The NLMA wishes all our readers a very Merry Christmas and a happy and health 2014.

Dr Bob Brown
Presidents Report – NLMA

2014 NLMA Bi-MEETING DATE CLAIMER:

For all Northside LMA Meeting & Membership queries contact:
Meeting Convener:
Miranda Russell, QML Marketing Office,
Contact Details;
Phone: (07) 3121 4574, Fax: (07) 3121 4972
Email: Miranda.Russell@qml.com.au

Meeting President:
Dr Robert (Bob) Brown
Website and Link:
Northside Local Medical Association Website
Link: http://northsidelocalmedical.wordpress.com/

Meeting Times: 7.00 pm for 7.30 pm
Next Meeting: 11th February 2014
2014 Dates:

1. 11th February 2014
2. 8th April 2014
3. 10th June 2014
4. 12th August 2014
5. 14th October 2014
6. 9th December 2014

Meeting Treasurer:
Dr Graham McNally
Contact Details;
Phone: (07) 3265 3111
Postal Address: C/- Taigum Central Medical Practice, Shop 1, 217 Beams Rd, Taigum Qld 4018

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT Dr CHRISTIAN ROWAN

Queensland Coalition for Alcohol Action

Dear members,
As we approach the end of another busy year, I'd like to share with you the positive work being done by the new Queensland Coalition for Alcohol Action (QCAA) which was officially launched in Brisbane on Thursday 28 November.

The Coalition is a group of like-minded organisations 'committed to working together for action on alcohol in Queensland.' Foundation Members of the QCAA include; AMA Queensland, Healthy Options Australia, Foundation for Alcohol Research and Education, Lives Lived Well and the Queensland Alcohol and Drug Research and Education Centre.

The Coalition's initial aims are to identify ways of creating a long-term cultural change that will reduce alcohol harms and improve the health and well-being of Queenslanders.

QCAA is modelled on the National Alliance for Action on Alcohol (NAAA) and seeks to harness the expansive individual expertise of each participating group and capitalise on this wealth of knowledge and experience in a collaborative way.

AMA Queensland is represented on the Coalition by respected maxillofacial surgeon Dr Anthony Lynham, a passionate advocate for the reduction of alcohol-related harms.

As an addiction medicine specialist myself, I am deeply concerned by the ongoing health, social, emotional and financial costs being placed our communities by dangerous and excessive alcohol consumption and behaviours.

The Coalition has developed an evidence-based Five Point Plan which, if implemented broadly, will deliver a reduction in alcohol-related harms and violence.

The key principles of the Queensland Coalition for Alcohol Action (QCAA) Five Point Plan:

1. Wind back late night trading hours and continue the moratorium on late night trading
2. Control the density of licensed premises
3. Prevent the harmful discounting and promotion of alcohol
4. Enforce responsible service of alcohol requirements
5. Collect data on alcohol sales, consumption and harms

It is widely understood that the negative consequences of alcohol don't just affect the drinker; they also impact families, colleagues, neighbours, communities, law enforcement officers and health practitioners.

The QCAA plan acknowledges that no particular action on its own can substantially reduce alcohol-related harms; it requires a range of complementary strategies that work together to deliver sustainable outcomes.

We look forward to working with our QCAA partners further next year and will be encouraging the Queensland Government to adopt and implement the Five Point Plan. Any doctors who would like to be involved in the Coalition or give feedback should contact AMA Queensland's policy team by calling (07) 3872 2222 or emailing policy@amaq.com.au.

I would like to take the opportunity to thank you for your support this year and wish you and your families a safe and happy festive season.

I look forward to working with you again in 2014 for what promises to be an important year for the medical profession.

Dr Christian Rowan, President
AMA Queensland

Burpengary Creek

Burpengary Creek is located about 40 kilometers north of Brisbane. It has a total catchment area of 7,960 hectares and is serviced by Moreton Bay Regional Council. The Burpengary Creek catchment forms part of the larger Deception Bay catchment encompassing two distinctive creeks–Little Burpengary Creek (6,360ha) and Burpengary Creek (6, 360ha). These creeks flow into Deception Bay just south of the mouth of the Caboolture River, which is south of Bribie Island. Burpengary Creek begins in the D'Aguilar Ranges which is a height of 340 metres above sea-level and the Creek continues flowing down the mountain slopes into Narangba, through the pine forests adjoining Oakey Flat Road. Its journey then flows into the residential areas of Morayfield and Burpengary before joining the ocean at the southern end of Deception Bay. Easy boat ramp acess for fishing and mud crabbing recreation areas.

Burpengary is known as the 'place of the wattle trees' and holds a deep significance for the Aboriginal communities that lived along the creek area where they found it valuable for camping, fishing, canoes making and access to the coastline. The last male of the local tribe, Menvil Wanmurarn, was buried alongside the Creek when he died in 1900. In 1842 Robert Dixon developed the first map of the area, marking Burpengary Creek as Cuthbertson Creek. Burpengary Creek was well settled by 1851 and used for grazing cattle and growing sugar cane. The dairy industry struggled and quickly was overtaken by the Australian Paper Manufacturing (APM) Forests cultivating 20,000 hectares of Pine Tree Plantations by 1958. APM sold it to a South Australian property developer. Caboolture Shire's draft strategic plan had listed the land for basic rural activities and the development of urban and rural residential properties.

An estimated less than 7.5% of the original vegetation within Burpengary Creek catchment remains. There are two types of forests evident mangroves along the shores of Deception Bay and the tea trees and paperbark forests in the freshwater wetlands. The bulk of the catchment area includes eucalypt forests, with vine forests / shrubs and riverline forests running sparsely along the edge of Burpengary Creek. Alongside Deception Bay Road is the largest undisturbed Tea Tree and Scribbly Gum forest in south-east Queensland and is located in Freshwater National Park. Other species found within this region are Smooth Barked Gums, Stringy Barks, Iron Barks, Brush Box, Hoop Pine, Cedar, Ash and Tulip Oak. A diverse range of native animals call Burpengary Creek catchment home there are over 140 bird species observed along Burpengary Creek includes the Eastern Whipbird, Noisy Friarbird, Galah Sulphur-crested Cockatoo, Tawny Frogmouth, Laughing Kookaburra, Kingfishers, Honeyeaters, Australian King Parrot and Australian Magpies. Endangered Australian frog species inresidence are the Giant Barred Frog, the Ornate Burrowing Frog, the Rocket frog and the Whistling Tree Frog. Other snakes and reptiles that can be found within this region are Coral snake, Burton's legless lizard, Eastern water dragon, Bearded Dragon and the Lace monitor. Native mammals include Northern Brown Bandicoot, wallaby, and platypus. Parks along the Creek allow family picnics, flying kites, and bird-watching at the Caboolture Regional Environmental Education Centre is also another popular pastime.

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

UPDATE ON THE BAD & NOT SO BAD NEWS

First the bad news, and a rapidly developing controversy in South East Queensland.

A medical insurer has commenced a "Queensland experiment" offering patients of a selected cohort of general practices the opportunity to have preferential access including rapid access and bulk billing. The experiment looks suspiciously like an attempt to create a USA-style Health Maintenance Organization. The AMA has a policy opposing HMOs or, more precisely, opposing the managed care that they espouse. Managed care means less clinician flexibility in determining management pathways, and usually means a capped budget for care of specified diagnoses (the diagnosis being more important than the patient).

It is early days yet, and the available information is incomplete. But, although the trial was initiated at a time of year when medical politics traditionally goes quiet and risks letting impending crises slip under the radar, AMAQ is right on top of this announcement and will be monitoring its implementation closely.

Next, the not-quite-so-bad news: On Tuesday 10th December, the AMA released its recommendations in the Report Card to improve the health and wellbeing of Aboriginal and Torres Strait Islander children in their early years, including:
A national plan for expanded comprehensive maternal and child services
 extension of the Australian Nurse Family Partnership Program of home visiting;
 support for families at risk of neglect, abuse and family violence;
 reduced rates of incarceration of Aboriginal people and Torres Strait Islanders;
 increased participation by Aboriginal people and Torres Strait Islanders in benefits of the economy, especially employment and entrepreneurship;
 increased school attendance;
 increased sense of cultural identity and self-worth;
 improved living environment;
and culturally appropriate measures of early childhood development and wellbeing.

The AMA Indigenous Health Report Card, The Healthy Early Years – Getting the Right Start in Life, is available on the AMA website. https://ama.com.au. Click on Dr Hambleton, Launch of AMA Indigenous Report Card, Parliament House 10 December 2013;

Medical Board to Resume Patel Action

On the one hand, you'd think they'd leave the poor beggar alone. On the other hand, some might argue that the profession has standards to maintain. On the basis of this, I've added another paragraph to my Councillor's report for the Newsletter:

The Medical Board has announced that it has decided to renew its disciplinary action against Jayant Patel in the interests of protecting the public. This announcement is a reawakening of the following controversy.

On the one hand, you'd think they'd leave the poor bloke alone; after all he's been through. Surely he has paid a debt to society, and maybe fully repaid what he owes society. Don't forget the legal principle of double jeopardy – you can't be tried for the same crime twice. (OK, his offence against the Medical Board rules was different from his offence against criminal law or the fraudulent registration, but the Medical Board prosecution arises from the same set of facts and circumstances.) And the prosecutors have already spent an awfully big swag of public money hounding him, and this smacks of sending good money after bad.

On the other hand, the public has a right to be protected, and maybe the litigation that Patel has faced so far has not sent a strong enough message to the public that they are going to be protected from another Patel. Importantly for my medical readers, we do have standards to maintain, and we cannot tolerate the whiff of a bad apple in the barrel making all the others seem rotten. We need to know that the public regards our profession as all being of a high standard. This is a question of reinforcing the faith that the public has in us, a faith that must be justified, and a reputation that is publicly seen to be watched closely by the Medical Board.

So, between the public interest in being protected, and the profession's interest in eliminating any visible taint, maybe the balance does lie in pursuing a high-profile individual case (I use the word "case" deliberately because he has long ceased to be a person in the public perception). I really don't know the answer, but my personal gut feeling response (NOT any evidence-based response) is that the medical profession should aim to be, like Caesar's wife, above suspicion.

RDMA Networking Meeting 29/11/13

RDMA President Kimberley Bondeson Introduced AMAQ President Christian Rowan, (pictured top right corner). (Clockwise): Members enjoying the evening included; Peta McLaren & Vas Kasan. Pravin Kasan & Bob Brown Northside LMA President.

Christian Rowan & Ray Huntley, Jenny Grew, Wayne Herdy Vice President, Cheryl McNally & Gabrielle Peterson, (bottom right corner).

Andrew Butler, Roderick Chua, Arnold Dela Cruz & Jai Raj (left hand corner). Wayne Herdy, Kimberley Bondeson & Bob Brown. Vas Kasan & Maureen Buzacott.

Jenny Grew & Christian Rowan. Glenn Sproles & Emily Kwan (Top Left Corner).

AMAQ BRANCH COUNCILLOR REPORT
GREATER BRISBANE AREA
Dr KIMBERLEY BONDESON

AMA COUNCILLOR'S COLUMN

It has been an interesting month, as you can see from my president's report. However, I wanted to introduce a topic which inspired me on our recent AMAQ conference which was held in Santiago.

The story begins with the history behind the "Hospital by the River", which I am sure many of you have heard of at some time during your medical career. The fistula hospital, "Hospital by the River" was founded by 2 Australian obstetrician and gynaecologists who travelled to Africa on a holiday, and stayed about 40 years ago. They founded a hospital to treat rectal/ vaginal fistulas, caused by obstructed labour in young African woman. Young girls in Africa are generally malnourished, and have very small pelvises. They are engaged at 12 yo, married at 13 yo and pregnant at 14 yo. There is no antenatal care or pregnancy care. They go into labour, and the baby is too big for a normal vaginal delivery due to the small pelvis. The mothers labour for about 3 days, until the baby dies. They then wait, until the head has collapsed and involutes, and they are able to deliver. However, this wait and the pressure on the rectum and vaginal wall causes necrosis of the tissue, and these young girls are left with faecal and urine incontinence. They are discarded by their husbands, and return to their families, who also do not want them. They are normally put in a lean to away from the family due to their smell and their incontinence. Eventually, if they are fortunate, they find their way to the fistula hospital in Hargesia.

One of the original founders, Dr Hamlon, is in her 90's and still operating 6 mornings a week. One of our guest speakers was a Dr Rod Thelander, an experienced rural GP from Western Australia. Rod is a University of Queensland graduate, and did his post graduate training at the Royal Brisbane Hospital, Cairns Base Hospital and with terms in South Africa and Scotland. He and his wife, Sandy regularly attend the AMAQ conferences each year.

This year Rod gave a talk, entitled 'Medical Aid and Education in Africa'. Rod is involved with a joint project that also involved the University of Western Australia which involves the teaching of medical students at the small medical school with the University of Hargesia. The town of Hargesia is the Capital of Somaliland which is located on the north west part of Africa, bordered by Ethiopia and Djibouti. Somaliland is a republic located within Somalia. So it has its own government and its own laws.

The University of Hargesia grew as a result of the Fistula Hospital and this is nearby.

This project is coordinated by "Australian Doctors for Africa" and the University of Western Australia.

Twice a year, 4-5 Australian Doctors travel to Hargesia (with security) to teach the medical students in their final year of medicine basic skills. These students are quite isolated, and have effectively been learning medicine by correspondence. They require teaching in Basic History Taking, how to take blood pressure and a pulse. Clinical Examination teaching is also required.
From Rod's description and he has been going on a regular basis, you fly in with a small group of doctors, and for a 2 week period teach the final year medical students. You don't have to be a specialist with surgical or obstetric skills, though these are extremely welcome and can be utilized. General Practitioners are welcome. Security is extremely tight. These teaching trips are just that, teaching, it is not a visit to socialize in the villages or townships, due to local security concerns.

I put my hand up, along with Dr Wayne Herdy, along with two of our own Queensland Obstetrician and Gynaecologists, to go on one of these trips to teach, at a grass roots level. My thoughts are that we may be able to put together a Queensland Team each year who would be willing to donate their time to help teach these final year medical students. At a very basic level, these African medical students who are soon to be doctors in that country, may be able to introduce basic changes in cultural acceptance of these early marriage and pregnancies which could avoid the formation of these fistula's and the social consequences for these young woman. The next AMAQ conference in 2014 is in Capetown in South Africa, and if we are able to, it would be ideal to dovetail our first visit after the AMAQ conference in September, 2014. Dr Herdy and I are planning initially to travel with Rod, as an introduction to Hargesia. It is very early days in the planning, and we are open to any suggestions.

Anyone who is interested, please talk to myself, or Dr Wayne Herdy. My mobile is 043 898 6727.

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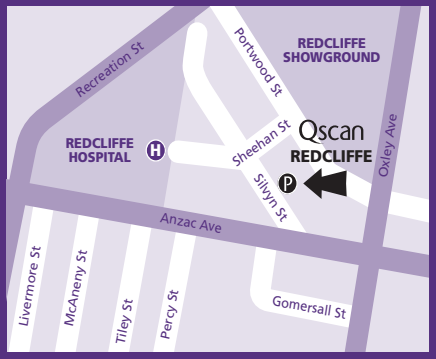

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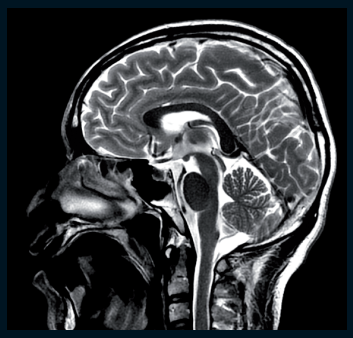
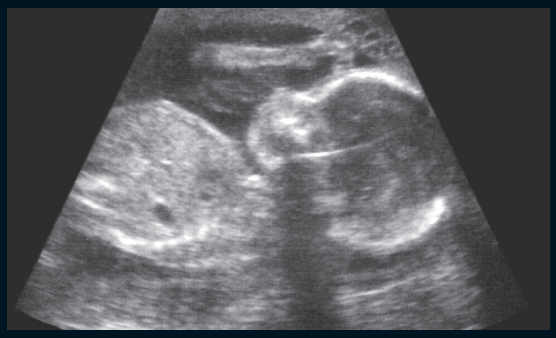
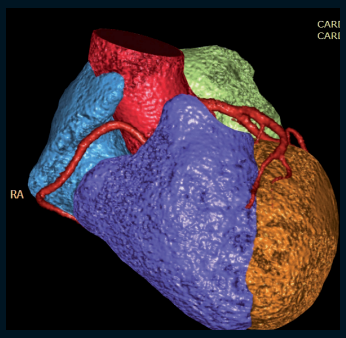

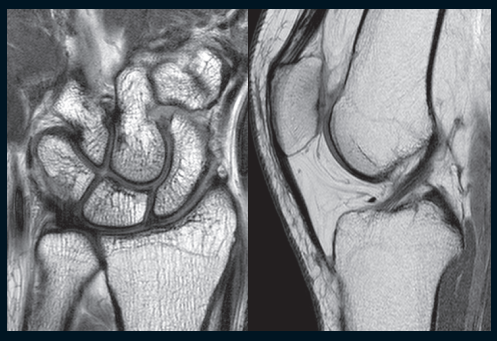
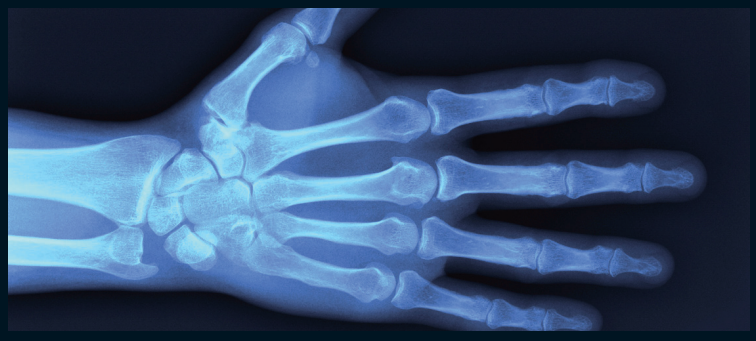

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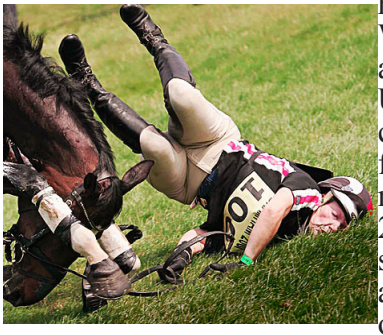
Having never fallen from a horse, I still have a healthy respect for jockeys who do this for a living. It is a long way down to the ground when you're in the saddle and at speed the likelihood of injury climbs exponentially.

The current record for the world's fastest horse is held by Winning Brew, a two year old US filly who covered two furlongs (402 metres) in 2008 in 20.57 seconds at an average speed of 70.76 km/h.



That's mighty fast even compared to Usain Bolt who covers 100 metres in 9.58 seconds, averaging 38.14 km/h. Even at low speeds falling can cause severe injuries as 46 Australians find out every day when they fall and break their hip.

One in nine of these individuals will then go to a residential aged care facility instead of going back to the family home. Celebrity status provides no immunity from injury with the Queen Mother falling and breaking her collar-bone in 2000 and then fracturing her pelvis in another fall in 2001 at the ripe old age of 101.

Royal children are renowned for their exuberance and her great grand-daughter Zara Phillips fractured her collar-bone in 2008 when she fell off her beloved horse Tsunami II. Sadly, Tsunami II broke her neck in the fall and was promptly euthanased.

In 2010 Olympic training Zara fell again from High Kingdom. But this time she was uninjured and was wearing a high-tech airbag jacket that probably saved her from an orthopaedic appointment. Ms Phillips was wearing a jacket which inflates when a rip-cord attached to the saddle is pulled when the rider and the horse have parted company.

A CO_2 canister inflates a bladder in the jacket in under 0.5 second, protecting the rider's chest and supporting the neck. The bladder remains inflated for about one minute which is just long enough to get back on your horse.

Our very own Superman (Christopher Reeve) may never have suffered fractures of C1 and C2 if that technology had been available when he fell off his horse in 1995.

Motorcycles travel considerably faster than humans with the Suzuki Hayabusa able to reach speeds of 312 km/h prior to the installation of a speed limiter in 2001.

Whilst no one could seriously think that falling off your motorbike at that speed is survivable there is a good case for all motorcyclists to wear airbag jackets as well as helmets. An ounce of prevention from your $200 Motorair airbag jacket may just save your life.

Suzuki Hayabusa GSX1300R
For: The world's fastest production bike.
Against: There are no roads to match its performance.
This bike would suit: Doctors in a hurry.
Specifications:
1340 cc 16 valve 4 cylinder petrol
128.4 kW power @ 10,100 rpm
132.6 Nm torque @ 7,600 rpm
6 speed manual, chain drive
Top speed 299 km/h (limited)
0-100 km/h in 2.6 seconds (still in first gear)
6.4 l/100 km (combined)
$19,290 + ORC

Fast facts:
Hayabusa is the Japanese name of the peregrine falcon, the world's fastest bird.
Peregrine falcons prey on blackbirds.
The Honda's CBR1100XX Super Blackbird was the previous fastest production bike in the world.
Motorcycles riders are 20-30 times more likely to die in an accident than car drivers of the same age.

Zara Phillips was recently spotted riding her horse with a baby bump.

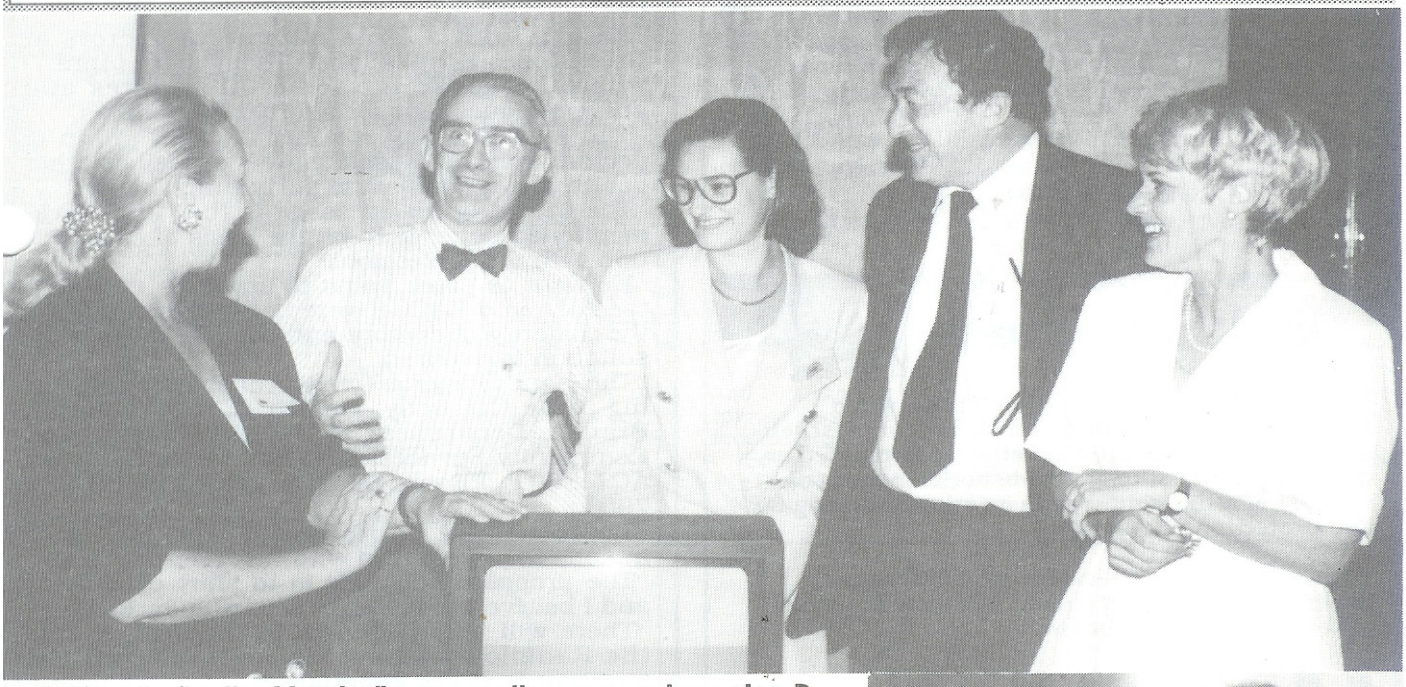
Safe motoring,

Doctor Clive Fraser

SNAPSHOT FROM THE PAST New Group to Form on Northside
REDAMA Newsletter from No 34 April 1992, Page 1

REDAMA R.E.P.O.R.T.

Official Newsletter of the Redcliffe & Districts Local Medical Association No 34 APRIL, 1992



FUN for all after the March dinner meeting as guest speaker Dr Frank Cunningham talks with Sigma's representatives, Pamela Tappin (left), Sarah Hart (centre) and Cluny Seager and AMA council candidate, Dr Michael Cohn. Full story page 6

New group to form on the northside

A NEW, and new-style Local Medical Association is to be formed on the northside of Brisbane next month.

The Northside LMA will hold its inaugural meeting at the Powerhouse, Kingsford Smith Drive, on Tuesday, May 19.

The meeting will be sponsored by Pfizer Qld., which has a policy of supporting medical groups throughout the State.

Redcliffe LMA president, Dr Bob Brown is a member of the steering committee behind the formation of the new group.

He said it would not meet monthly, like other groups, but would be convened when suitable speakers or appropriate topics were identified.

Dr Brown said it was hoped the Northside LMA would become the umbrella organisation for all politico or craft medical groups in the region.

"Each group will continue to operate under its own constitution but it is hoped that when a Northside LMA meeting is called, the others will defer to it," Dr Brown said.

Anyone wishing to attend the May 19 meeting should contact Dr Brown at 265 4555.

Valerie Pinel, winner of a gift basket in the Early Birds Quiz sponsored by QML admires her reward for being so clever at the inaugural gathering of the medical receptionists in the Peninsula area last month. A full report on the new group will be published in the next edition.

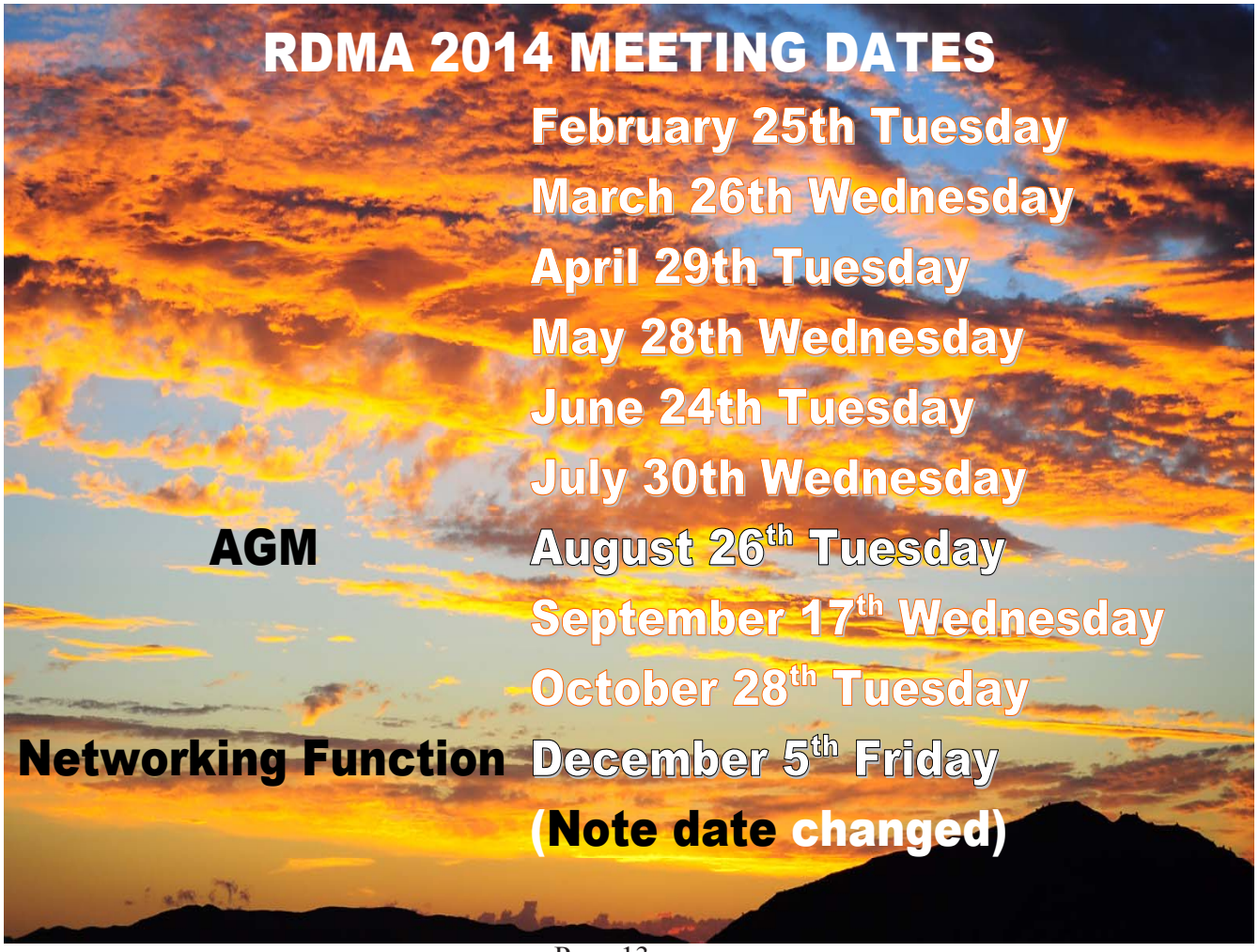
EATING IN THE UK IN THE FIFTIES

For those of you who are old enough to remember, enjoy. For the rest - it's a history lesson!! Very surprising how time and memory has taken its toll. Have things really changed this much in our time?

Pasta had not been invented.
Curry was a surname.
A takeaway was a mathematical problem.
A pizza was something to do with a leaning tower.
Bananas and oranges only appeared at Christmas time.
All crisps were plain; the only choice we had was whether to put the salt on or not.
Water came out of the tap, if someone had suggested bottling it and charging more than petrol for it they would have become a laughing stock.
Rice was a milk pudding, and never, ever part of our dinner.
A Big Mac was what we wore when it was raining.
Brown bread was something only poor people ate.
Oil was for lubricating, fat was for cooking
Tea was made in a teapot using tea leaves and never green.
Coffee was Camp, and came in a bottle.
Cubed sugar was regarded as posh.
Only Heinz made beans.
Fish didn't have fingers in those days.
Eating raw fish was called poverty, not sushi.
None of us had ever heard of yoghurt.
Healthy food consisted of anything edible.
People who didn't peel potatoes were regarded as lazy.
Pineapples came in chunks in a tin; we had only ever seen a picture of a real one.
Cooking outside was called camping.
Seaweed was not a recognised food.
"Kebab" was not even a word never mind a food.
Sugar enjoyed a good press in those days, and was regarded as being white gold.
Prunes were medicinal.
Surprisingly muesli was readily available, it was called cattle feed.

The one thing that we never ever had on our table in the fifties ..... was elbows!

2014 Date Claimers



SNAPSHOT FROM THE PAST Breast Screening Seminar
REDAMA Newsletter from No 34 April 1992, Page 5

Public shows keen interest in breast screening seminar

A COMMUNITY awareness seminar on breast screening and mammography has attracted widespread public interest since it was launched on March 30.

The seminar is an initiative of the Redcliffe and Districts Local Medical Association as a contribution to developing greater public awareness of topical medical issues.

It will be held in the Redcliffe CWA Hall, Redcliffe Parade on Tuesday, May 12 at 7.30pm.

Joint sponsors are the Redcliffe and Bayside Herald newspaper and Medical Applications Ltd., distributors of Phillips Siemen equipment.

LMA treasurer, Dr Judy Tucker will take the chair for the seminar which has already attracted bookings from about 30 people.

The organising committee is expecting at least 100 to attend, including husbands who are being encouraged to join their wives for the evening.

The expert panel will be Dr Zelle Hodge, representing General Practice and womens health, radiologist Dr Evan Fraser, surgeon Dr Jonathan Davies and Sue Hall, representing Medical Applications.

Medical Applications will mount a pictorial display to support the speakers who will answer questions from the audience.

Posters have been sent to all practitioners in the Peninsula region for display in waiting rooms.

The Redcliffe Herald is promoting the seminar with a weekly display advertisement made available free of charge.

All local newspapers have been provided with weekly media releases and all metropolitan radio stations have been asked to broadcast community service announcements.

Dr Bruce Flegg has thrown his support behind the campaign by allowing calls for bookings to be made to his Kippa R ing receptionist.

Dr Flegg said the first calls started within hours of the seminar being announced in the Herald.

Dr Hodge, a member of the LMA and chair person of the AMA Womens Health Committee, welcomed the decision to stage the seminar.

She said there was an urgent need to impress on the community the importance of regular screening and mammography testing.

LMA President, Dr Bob Brown, appealed to all members to help promote the seminar by recommending it to appropriate patients.

Dr Brown said the seminar would be a valuable community service project with minimal in-put from the members.

"All are welcome to attend but the main point is to attract as many people as possible," he said.

CHERRABAH HOMESTEAD RESORT
CONFERENCE '92

Chance to enjoy bush breakfast at Cherrabah

THE chance of a real bush breakfast is one of the attractions for delegates to the 1992 Queens Birthday Post Graduate conference.

The conference will be held at Cherrabah Homestead Resort, near Warwick, on June 6, 7 and 8.

Convenor, Dr Geoff Hool, said the tariff of $99 per day for adults included three meals a day, as well as morning and afternoon teas.

"They have a bush breakfast facility, with a log cabin and big fire that will be most appropriate for the middle of winter," Dr Hool said.

While the theme of the conference will be "Medicine in the 21st Century" there will be a strong emphasis on social interaction for the weekend.

Cherrabah has been extensively upgraded since the LMA's last conference there eight years ago, and facilities are now considered top class.

The conference centre has become a popular destination for corporate and community groups looking for first class facilities in a rural setting.

Cherrabah also offers leisure activities including horse riding, bush walks, tennis, golf and a swimming pool for the truly hardy.

Dr Hool said it was necessary to make a confirmed booking for the conference facilities, with a cash deposit which would be forfeited if the conference does not proceed.

"We need a minimum of 20 delegates to justify the booking and we must know definitely by May 8," he said.

A registration form appears in this edition of Redama and a conference brochure has been distributed to all practitioners in the region.

The registration fee is $100 and accommodation prices are $99 per night for adults and $49 for children, including all meals.

Tax concessions for insurance through super

Insurance through super can be cheaper than ordinary insurance due to concessions on contributions into super that are subsequently used to pay the premiums. However, there are some key factors that should be considered before taking out insurance through super;

- Reduced product features available through super
- Preservation issues (TPD Own Occupation and Trauma cover)
- Potential tax on claim benefits
- Impact on maximum contribution limits
- Longer time to get money and potential for disputes
- Restrictions on nominated beneficiaries

The benefits of insurance inside super focus on reducing the effective cost but as listed above can create issues and disadvantages at time of claim if not properly assessed initially and reviewed regularly.

Insurance inside super – personal deductible contributions

If the individual chooses to hold insurance through super, personal deductible or salary sacrifice (concessional) contributions can be made to offset some of the premium cost.

Individuals with some employment income can claim a deduction on personal contributions into super if they meet certain requirements. The main requirement is that less than 10% of total assessable income (plus reportable fringe benefits and reportable employer super contributions) is attributable to employment as an employee.

Example – Life & TPD Cover

Jeff, aged 45, is self-employed and earns $250,000 p.a. after expenses as a GP. He wants to take out $1MIL Term Life and Total & Permanent Disability (TPD) which costs $1,767.59 pa.

	Outside Super	**Inside Super**
Assessable Income	$250,000	$250,000
Deduction on Contribution	$0	$1,767.59
Taxable Income	$250,000	$248,232.41
Tax Payable	$89,797.00	$88.975.49
Tax Saving	$0	$821.51

The above calculations are an estimate only.

In regards to Income Protection, it is generally better to hold this policy outside of super because there is no additional tax advantage holding the policy inside of super as the premium is tax deductible in both situations.

Things to note:

- Individuals must be eligible to contribute to super (i.e. under age 65 or 65<75 and meet work test)
- Concessional super contributions may exceed the contribution limit and be liable for penalty tax
- Tax may be payable on benefits when paid from super
- Upfront cost savings of insurance through super should be weighed up against the downsides to determine the value and appropriateness

Article written by Hayden White DFP & Cert IV Finance/Broking phone 07 54379900.
Representative of Poole & Partners Investment Services. AFSL 280 232 / ABN 24 093 450 394

COMPUTERS & GADGETS

Email: apndx@hotmail.com.

with Doctor Daniel Mehanna

The Google Nexus 5 Phone "Why The Fuss?"

The Google Nexus 5 Phone: Why the fuss? Finally after months of frenzied speculation the Nexus 5 smartphone has been released.

Nexus 5 & Apple 5S

But before we go into the details of the phone itself, I thought this month we would discuss why this phone, and in general why the "Nexus" line of phones is so important to the Android ecosystem.Every phone needs an operating system, not unlike a standard PC. There are several around now, the main players being IOS (by Apple), Windows (by Microsoft) and of course Android (by Google).

While Microsoft and Apple have taken a closed approach to their offerings, Google has gone the other way and actually not only gives its operating system for free to phone manufacturers but releases the code to the general public so programmers are free to modify and improve the operating system. This ensures as wide as possible adoption of their operating system by the phone manufacturers - as the old saying goes, it's hard to compete with free. Google in return makes it money by the advertising revenue it collects by keeping its users in the Google ecosystem and using Google search.

This open approach, although encouraging innovation does have some draw backs. The phone manufacturers are free to modify the operating system to improve (although this is debatable) the user experience and differentiate their phones from other manufactures' phones. Samsung, for example has developed its proprietary "touchwiz" interface. Although this sounds good in theory, more often than not, these interfaces are cumbersome, slow and clumsy, and are viewed by many to be more than a hindrance than an advantage. The other problem with these proprietary interfaces is that when Google does release an update to the operating system, it can take some months for the phone manufacturers to test their interface with the new operating system and pass the update to the end user. The result is "fragmentation" of the Android ecosystem whereby many users may be still stuck using old version of the operating system because their phone manufacturers cannot or will not update their phone's software. This has been and still is, a constant source of frustration to many users who although may have the latest phones, are at the mercy of the manufacturers as to when they can actually update their operating system.

It is partly for this reason that Google developed the Nexus line of phones.The Nexus phone is essentially a phone designed by Google in partnership and built by a hardware manufacturer (usually Samsung or LG) which runs the pure untouched ("vanilla") version of Android (currently version 4.4 - Kitkat), unencumbered by any phone manufacturer's modifications and "bloatware". The result is a phone that runs faster, cleaner and more efficiently - just how Google intended. The other advantage is that these phones are the first to receive the new versions of the Android operating system, as the updates are received directly from Google with no wait period. This is heaven for inpatient geeks

Apart from these advantages, the phone generally has great hardware specifications (although the quality of the Nexus camera has traditionally been a disappointment) with a great price and unbeatable value. The just released Nexus 5 can be bought for about $400, which is about half the price of the comparable Apple offering. This is partly because the phones are purchased directly from Google on line, cutting out the middle man. The last advantage is that Google times the release of each Nexus phone with the release of the latest version of the operating system so buying the latest Nexus phone means the user is also running the latest and greatest version of the Android operating system months before other android phones. Who could want more? Next month we will review the phone itself in detail.

Narangba Family Medical Practice

Job Vacancy

A part-time *(with view to full time if required)* VR Family Doctor for the Narangba Family Medical Practice (www.narangba-medical.com.au) as one of our doctors (Dr. Orr) is leaving to specialise.

We are a three doctor, fully computerised, non-bulk-billing practice established since 1986 in an outer, semi-rural northern suburb of Brisbane. The ideal candidate would be of an age where taking over the whole practice eventually would be a distinct possibility.

Contact: Dr Peter C. Stephenson, Mobile: 0403 151 602.

Practice Location: Opposite the Narangba Railway Station, Main Shopping Centre, beside the Narangba Pharmacy.
Street Address: 30 Main Street, Narangba Q 4504.
Postal Address: P.O. Box 3 Narangba Q 4504

MAJELLAN MEDICAL CENTRE

Job Vacancy

A VR, GP is required for a Scarborough Beachfront, Non-Corporate Practice which is 30 minutes from Brisbane's CBD. The Accredited Practice has private billing facilities, modern equipment and has staffing of nine doctors and registered nursing support.

The Medical Centre has a Computerised Skin Cancer Clinic, ultrasound machine and operating microscope. Allied Health staff are also on site. A candidate who is fluent in English, Afrikaans, Dutch, German or French languages would be an advantage.

Contact: Angela De-Gaetano (Practice Manager)
Practice Location: Majellan Medical Centre, 107 Landsborough Avenue, Scarborough Q 4020
Practice Phone: (07) 3880 1444 **Practice Fax: (07) 3880 1067**



Australian Medical Association Limited

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PO Box 6090, Kingston ACT 2604

ABN 37 008 426 793

T: (02) 6270 5400 F (02) 6270 5499
Website : http://www.ama.com.au/

"AMA Calls For Comprehensive Overhaul of Medicare Locals"

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA Submission to the Australian Government's Review of Medicare Locals. The AMA is calling on the Abbott Government to comprehensively overhaul the Medicare Locals model introduced by the previous Labor Government, including ditching the name, 'Medicare Locals'.

The call is included in the AMA's submission to the Australian Government's Review of Medicare Locals, which is being headed by former Chief Medical Officer, Professor John Horvath.

AMA President, Dr Steve Hambleton, said the AMA submission highlights significant problems in the design and implementation of Medicare Locals, and recommends fundamental changes to the model implemented by the former Government.

"We recognise the need for a network of primary health care organisations (PHCOs) to improve the integration of health services within primary health care and improve the interface between primary care and hospitals, but the current Medicare Locals model has not delivered," Dr Hambleton said.

"The performance of Medicare Locals against their objectives has been patchy, and there is little evidence of improvement over the divisions of general practice structure they replaced – despite significant additional funding.

"The starting point for the Review is to change the name – 'Medicare Locals' means nothing to the people who need access to quality primary health care services in their communities.

"It sounds like another layer of bureaucracy. The name should project an active role in looking after people's health."

In its submission, the AMA recommends reforms that focus on moving to a network of PHCOs that are: GP-led and locally responsive;
- focused on supporting GPs in caring for patients, working collaboratively with other health care professionals;
- not overburdened by excessive paperwork and policy prescription; focused on addressing service gaps, not replicating existing services; and
- better aligned with Local Hospital Networks, with a strong emphasis on improving the primary care/ hospital interface.

Dr Hambleton said GP leadership is vital. "GPs are the lynchpins of the health system and are acutely aware of existing gaps in access to care and the impact on patients of badly designed or poorly integrated health care services," Dr Hambleton said.

"There must be a principal role for GPs in decision-making if PHCOs are to succeed in targeting service gaps, supporting continuity of patient care, and facilitating patient access to much-needed services."

The AMA submission is informed by a recent survey of 1212 GPs from around Australia. The GPs were invited to share their views on the role being played by the current Medicare Locals.

The survey responses indicate that Medicare Locals have:
- failed to improve the coordination and delivery of primary health care services;
increased red tape and compliance costs;
- failed to communicate effectively with GPs;
not engaged meaningfully with general practice;
- duplicated existing services; and
been unable to demonstrate any improvement to access to after-hours GP services, despite significant extra funding.

Dr Hambleton said the AMA has lobbied for the Medicare Locals Review for some time, and welcomes this opportunity to provide input, including the very important grassroots GP feedback.

"The AMA will work with the new Government to implement sensible reforms that support improved access to care for patients," Dr Hambleton said.

The AMA submission is at https://ama.com.au/submission-australian-government-review-medicare-locals

19 December 2013

John Flannery 02 6270 5477 / 0419 494 761
Kirsty Waterford 02 6270 5464 / 0427 209 753
Follow the AMA President & Media on Twitter: http://twitter.com/amapresident or ama_media
Like the AMA on Facebook:https://www.facebook.com/AustralianMedicalAssociation

REDCLIFFE & DISTRICT LOCAL 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

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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 AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription Benefits

Don't waste time! Join now!

Monthly: Newsletters, Topical Educational Meetings, 3 Course Cuisine,

CPD Points & Attendance Certificate Available

Rounded off with the End of Year Networking Meeting

Get your membership benefits! Socialise! Broaden your knowledge!

Dear Doctors

The Redcliffe and District Medical Association Inc. have had another successful year of interesting and educative meetings on a wide variety of medical topics. Show your support for your Local Medical Association to continue the only local convocation for general practitioners and specialists to socialise and to discuss local and national medico-political issues.

Annual subscription is $100.00. Doctors-in-training and retired doctors are invited to join at no cost. This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and/ or speakers are most welcome.

RDMA SUBSCRIPTION FORM – INTERNET PAYMENT PREFERRED

Treasurer Dr Peter Stephenson Email: GJS2@Narangba-Medical.com.au.

ABN 88 637 858 491

1. **One Member (July to June: $100; Oct.-June: $75; Jan-June: $50.00; April-June: $25.00)**
2. **Two Family Members ($25 Discount each) ($150 pro rata)** (Please supply details for both members)
3. **Doctors-in-training and retired doctors: FREE**

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

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

1. ***EMAIL ADDRESS***: _____@_____

2. ***EMAIL ADDRESS***: _____@_____

Practice Address: _____ Post Code: _____

Phone: _____ Fax: _____

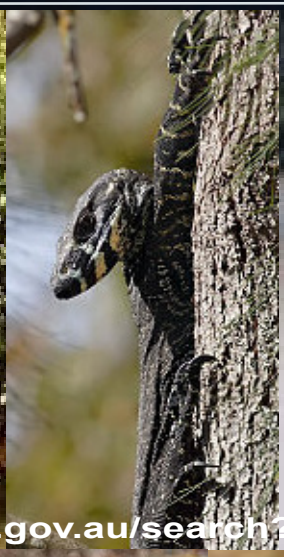
CBA BANK DETAILS: **Redcliffe & District Local Medical Assoc Inc:BSB**: **064 122 Account**: **0090 2422**

METHODS OF PAYMENT:

1. **PREFERRED INTERNET BANKING**
2. **PAYMENT BY DEPOSIT SLIP**: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. **ENCLOSED PAYMENT:** (Member Subscription Form on website, type directly into it and email)
   i) **Complete form & return:**
   - **c/-QML or Redcliffe & District Medical Assoc Inc. P O Box 223 Redcliffe 4020**

   ii) Or by email to GJS2@Narangba-Medical.com.au

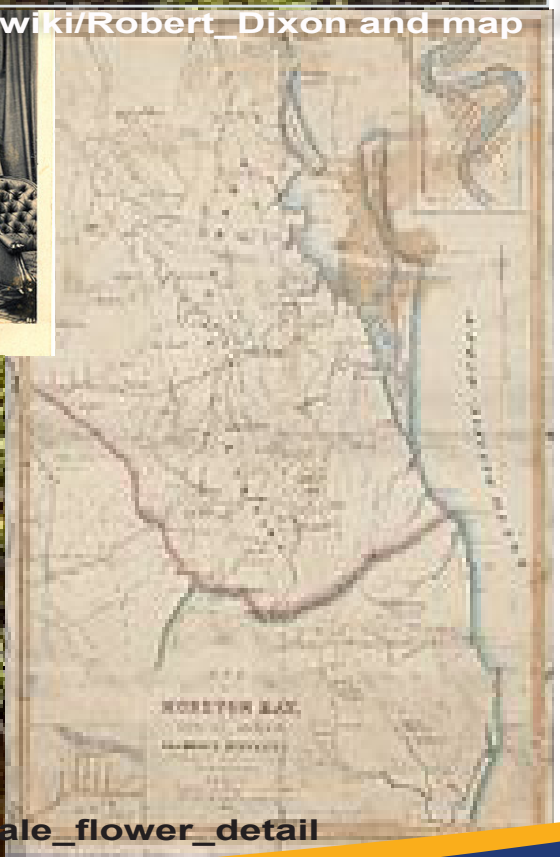
Where We Work And Live



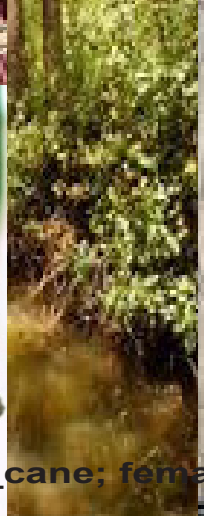
http://www.moretonbay.qld.gov.au/search?q=burpengary+creek

http://en.wikipedia.org/wiki/Eastern_Whipbird; Noisy_Friarbird; Tawny_Frogmouth; Lace_monitor

Burpengary Creek



http://en.wikipedia.org/wiki/Robert_Dixon and map



http://en.wikipedia.org/wiki/Sugar_cane; female_flower_detail