RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
JULY 2017

RATS OF TOBRUK: Continued

See Where We Work & Live on page 20.
http://anzacportal.dva.gov.au/sites/default/files/rats-of-tobruk-transcript

President's Report Dr Kimberley Bondeson

What a beautiful winter we are having. Cool nights and beautiful sunshine during the day. Canberra was -7 degrees Celsius last week, I admit that was a bit chilly and frosty. But there is no doubt that this is definitely one of the coldest winters we have had in the last few years. Which brings me to the electricity bills? When the electricity companies were privatised, the government stated that electricity prices would go down. The exact opposite has happened. Our politicians are often not very clever, and make decisions which are not thought through properly and have far reaching, unintended consequences.

The latest Pharmacy Pathology push, where Pharmacies are charging patients up to $220 for pathology screening tests for kidney, thyroid and liver function is part of a campaign for "preventative health care". No Medicare rebate is available. There are legal implications for GP's and specialists if they are dragged into this if, for example, a copy of the blood test, which is abnormal, is forwarded to them. I personally do not support this move. If a patient wants a blood test, then go to the doctor and have it ordered, interpreted and followed through correctly.

There is also a proposal for a non-doctor to chair the Medical Board of Australia. This is not a very bright idea – does a veterinarian run a Building and Construction Governing Board?

According to ''Australian Doctor" – July 2017 issue, legislation containing the clause "allowing community members to chair the board" would have to pass through every state parliament before the change can be introduced. The AMA has had this clause removed from a recent Queensland bill. However, what the other states are to do is yet to be seen.

On more sensible news, a national maternity services plan that basically excluded GP's has been dumped a week before its release. It is unbelievable to think that a draft National Framework for Maternity services had been written up without any input from GP's and Obstetricians. The draft plan glossed over clinical issues such as vitamin K prophylaxis and evidence for midwife-led vs obstetrician-led care. It was drawn up by a working group led by midwifes and state bureaucrats.

And for further, really enjoyable news – Queensland won the State of Origin. Fantastic game! Loved to see the older players (injuries and all), get out there and play.

Kimberley Bondeson,

RDMA President

RDMA & NLMA's Joint Newsletter

Welcome from

Dr Robert (Bob) Brown

President Northside Local Medical Association

Note: Doctors in Training RDMA Membership is Free
RDMA Meeting Dates Page 2.

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

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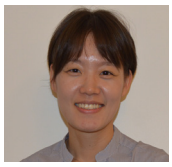

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RDMA 2017 MEETING DATES:

For all queries contact Anna Wozniak
Meeting Convener: Phone: (07) 3049 4444

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Wednesday	February	22th
Tuesday	March	28th
Wednesday	April	26th
Wednesday	May	24th
Tuesday	June	27th
Tuesday	July	25th
ANNUAL GENERAL MEETING - AGM		
Wednesday	August	23th
Tuesday	September	12th
Wednesday	October	25th
NETWORKING MEETING		
Friday	December	1st

RDMA NEWSLETTER DEADLINE

Advertising & Contribution 15 July 2017
Email: RDMANews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

NLMA 2017 MEETING DATES tbc:

For all queries contact Graham McNally
Meeting Convener: Phone: (07) 3121 4029
Email: gmcnally1@optushome.com.au

W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants

Time: 6.45 pm for 7.15 pm

1	February	14th
2	April	11th
3	June	13th
ANNUAL GENERAL MEETING - AGM		
4	August	8th
5	October	10th
6	December	12th

Next Meeting Date 25th July 2017

RDMA Meeting for 27.06.17

Dr Kimberley Bondeson, RDMA President Introduced the Sponsor Medtronic Representative Scott Steele who in turn ntroduced the Speakers for the night: Dr Daniel Hagley, Vascular Surgeon, whose Topic was Veins, Veins, Veins

Below: 1. Dr Daniel Hagley Speaker

Clockwise: 2. Medtronic Represenative Scott Steele

3. Dr Daniel Hagley and Scott Steels,

4. **New Member** Andrew Lee with Primila Balakrishnan.

5. **New Member** Dr Georgie Bright with Meeting Convener Ms Anna Wozniak

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 25th of July 2017**

TIME: 7pm for 7:30pm

VENUE: Regency Room – The Ox, 330 Oxley Avenue, Margate

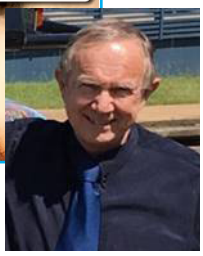
COST: Financial members, interns, doctors in training and medical students – FREE. Non-Financial members – $30 payable at the door (Membership applications available).

AGENDA:

7:00pm	Arrival & Registration
7:30pm	Be seated – Entrée served Welcome by Dr Kimberley Bondeson – President RDMA Inc.
7:35pm	Sponsor: Genesis CancerCare Queensland
7:40pm	Speaker: Dr David Schlect – Radiation Oncologist Topic: Radiation Therapy for Skin Cancer
8:15pm	Main Meal, Question Time
8:40pm	General Business, Dessert, Tea & Coffee

RSVP: By Friday 21st of July 2017
(e) RDMA@qml.com.au or 0466 480 315

INSIDE THIS ISSUE:



Its Here Again Aug-Sep, 2017 The Surf & Turf Variety Bash

SUPPORT A WORTHWHILE CHARITY,
Variety The Childrens Fund
Variety supports disadvantaged & sick children and their families.

Dr Wayne Herdy is again an entrant for this year's Bash too

GET YOUR TAX DEDUCTION:
DONATE at the new website link:
https://https://www.variety.org.au/bash/bashers/car-5555/

NORTHSIDE
SLEEP & THORACIC

PRESENTS.... SORTING OUT THE SLEEPY

Dr James Douglas and Dr Andreas Fiene invite you to tour their new sleep lab at North Lakes. The night will include a look at what goes on in a sleep study, a presentation on "sorting out the sleepy" and an update on the clinic's referral process.

Date: Tuesday, 29th August 2017

Venue: Northside Sleep and Thoracic,
1 Winn St (Cnr Gregor St West), North Lakes QLD 4509

Agenda:
6:30 pm - Registration drinks and canapes
6:45 pm - Meet and greet the sleep physicians
7:00 pm - Sleep lab and clinic tour
7:30 pm - Presentation: Sorting out the sleepy
8:00 pm - Q & A

RSVP: Tuesday, 22nd August 2017
Laura Sorensen – Practice Manager 07 3635 8420
practicemanager@northsidesleepandthoracic.com.au

Prompt response is advisable as places are limited. Please provide mobile number so a reminder text can be sent on the day of the event.

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

AMA Federal National Conference

I recently bought to the attention of the AMAQ Council, the difficulties which are been experienced by specialist's doing outreach clinics, and being presented with very large (100 pages) patients summaries and notes, in no particular order, prior to the Specialist seeing the patient in clinic.

Dr Michael Gannon, AMA federal president was also present at this AMAQ Council Meeting.

The general consensus was that the Specialist (or any doctor for that matter), when presented with this health history and data, is considered to have read it. And yes, this has legal implications for the doctor.

The advice was for each particular doctor in this position, to seek advice from their medical defence team.

Dr Gannon was particularly surprised that this situation had arisen, and will take it further.

I would like to welcome Dr Geoff Hawson, on to the RDMA executive as the Retired Doctors Representative.

I look forward with interest, as I am sure most of RDMA members are, on his contributions on this particular subject. (Dr Hawson is also Retired Doctor Representative on AMAQ Council).

Photos taken at the Dinner For The Profession:

Photo 1. Dr Bob Brown.

Photo 2. Dr Catherine Yelland and Dr Kimberley Bondeson

Photo 3. Geoffrey Hawson and Kim Hawson,

Photo 4. Dr Bill Boyd, AMAQ President

Sincerely

Kimberley Bondeson

CEO UPDATE:

AMA QUEENSLAND CONTINUES OHO REFORM CAMPAIGN

In early 2016, AMA Queensland released a discussion paper which called on the Queensland Government to look at ways in which the Office of the Health Ombudsman (OHO) could be reformed. We developed this discussion paper in response to repeated feedback from members regarding the performance of the OHO and its adherence to principles of natural justice.

As a result of AMA Queensland's strong and sustained advocacy on these problems our members communicated to us, the Queensland Parliament's Health Committee, which has oversight of the OHO, began an inquiry in mid-2016 to examine the OHOs performance. AMA Queensland provided a submission to the inquiry and then-AMA Queensland President Dr Chris Zappala appeared before the inquiry as a witness to provide verbal evidence on the OHOs effectiveness.

Following the conclusion of its inquiry, the Health Committee presented its report on the performance of the OHO in December 2016, making four recommendations it believed would help improve the OHOs performance, three of which the Government accepted and which it intended to implement in an amended Health Ombudsman Bill in 2017.

AMA Queensland provided feedback on these recommendations and a number of other changes the Government flagged for potential inclusion in the Bill.

During this period, AMA Queensland became aware of plans to change the National Law Bill to allow the Ministerial Council to appoint a community member of a National Board as Chairperson. AMA Queensland advised the Government that we strongly opposed this move. The chair is a very influential and challenging position and the individual appointed to the role requires a detailed understanding of the medical profession. We heavily advocated against this proposal through direct discussions with the Minister and by asking AMA members to contact their local MP to advise them of their own opposition to it.

In June 2017, the Queensland Government introduced the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017. We were extremely pleased to see our efforts to influence the Government's thinking on the Chair of the National Board had resulted in that provision being removed from the first tranche of the Bill. We are advised it may reappear in future tranches of the Bill so we will remain vigilant on that front.

The Bill also contained a number of amendments to the Health Ombudsman Act. Some of the amendments were common sense, however there was also a provision which would have given complainants and those who are subject to a complaint, the ability to waive their right to three-monthly progress updates on the progress of their investigation. AMA Queensland strongly opposed this, as we felt the 3 monthly update reports are an accountability measure which work to ensure the OHO responds to and seeks to resolves complaints in a timely manner and helps instil public confidence in the regulator.

Additionally, we did not support the expansion of the powers of the Health Ombudsman to allow it to take immediate action "in the public interest" as we felt the notion of "public interest" was far too broad and open to interpretation.

Dr Shaun Rudd gave evidence at the inquiry on 17 July, 2017. AMA Queensland believes further improvements and further vigilance are required to ensure that the current Queensland framework functions as effectively as possible. We are seeking further amendments to change Queensland's mandatory notification laws to adopt an exemption such as the one which operates in Western Australia. We also want to ensure that the proposal to appoint a community member of a National Board as the Chairperson does not resurface in future tranches. We will continue to work with the Government to ensure the interests of our members and the public are heard.

I always welcome your feedback so please feel free to drop me a line at ceo@amaq.com.au

Off The Beaten Tourist Track To Mongolia

DR WAYNE HERDY

The main street in the capital city

My latest sojourn abroad was into Mongolia. Hey, how many people do you know who have been to Mongolia.

Plan A was to go trekking in the Gobi, the world's biggest desert (excluding the polar regions). Due to the lack of competence or lack of interest on the part of the Australian travel agent, Plan A was aborted. The travel agent was more interested in charging outrageous penalty fees for a changed itinerary than in providing customer service. But that's another story – and maybe the last time I'll use a travel agent to get me into the wilderness. I've always managed better doing the arrangements on the internet; at least then I know what has been done and can only blame one person if it's not done right.

Anyway, despite missing out on the Gobi proper, I at least had a few days in the capital Ulan Bataar, and got a taste of the land and the culture.

Ulan Bataar boasts a population similar to Brisbane, but looks like an overgrown village. No big thoroughfares, no big stores, not a lot of hotels. The population is hidden away in high-density apartment blocks, presumably tiny by Western standards. The main street looks more like a country village than an urban metropolis. And international standards haven't hit home yet – a five-star hotel would barely rate three stars in New York.

Genghis Khan with traditional Monglian script.

I'm no social snob but I am a car snob, and I often judge countries by their transport. This is a land where Kia is king and Toyota is prince. I saw a mere 5 Mercedes Benzes –admittedly one was top-range but the others were low-range and one quite ancient.

The Mercedes showroom (out of town on the airport road) was a showroom only – no cars. I saw only one BMW, a reasonably late model X5. I have forgotten what fuel prices were, but about 10-20% less than Australia. This is a country that has not yet learned how to tax its people.

One Peice of Modernity.

As a tourist, I am an incurable foodie. They say nobody goes to Mongolia for the food. How much boiled mutton can you eat? They are also strong on dairy, especially cheese, but not recommended. For what we think of as an Asian country, I was surprised that rice and noodles are exotic, not at all accepted into the mainstream diet and not common in takeaways. I did see a few Pizza Huts, and one KFC, but mercifully not a single Maccas.

Continued on Page 8

Off The Beaten Tourist Track To Mongolia Continued:

A few oddities about Ulan Bataar. Public

A Yert in the City Centre

transport is confined to buses and taxies. It must be the only large Asian city without a high-speed subway. And the city is criss-crossed by large pipes – I forgot to ask what they are for but I suspected they carry steam, in a city that is frozen for 2/3 of the year.

I used to think of Mongolia as a kind of Western suburb of China. Very wrong! Culturally and socially, they are much closer to East Russian. The language, written in the Cyrillic alphabet, is very similar to Russian. The websites say the people are hostile to Westerners (indeed, unaccepting of all tourists) – also very wrong. The people were lovely, and if anything curious to see Westerners, of

High Density Housing is everywhere. Cheaper to heat in Winter.

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Off The Beaten Tourist Track To Mongolia Continued:

Market: For Locals not Tourists.

whom I saw few. Most foreigners appeared to be Chinese, and I think most were there for business, not tourism.

In the good old days of Genghis Khan (Chinggis Kan, the"great khan" and father of the fabled Kublai Khan of poetic fame), the Mongolian Empire extended into Central Europe and covered China) Mongolia was eventually dominated by China but has been independent for half a century. Soviet coins can still be purchased in the flea markets, and they might even be genuine. Mongolia

What are these pipes for?

is historically a nomadic country. The pastures are too sparse to support a static population, and there are still whole cities that are nomadic, living in the yerts, or round tents. The economy was based on primary production of wandering herds of sheep or goats.

The economy has now switched to mining and we can expect a dramatic change in living styles and living standards in the coming decade or so. And in the standard of their cars.

Would I go back? Or recommend that my friends go? An emphatic yes to both, with a few provisos. I'd go soon, before the culture gets too contaminated by the expected mining boom. Personally, I'd make my own travel arrangements next time, and I'd be sure that the desert trek part was booked properly before parting with any cash.

Don't expect European standards, but it's not third-world either. Don't go in winter, unless you really need to experience minus 30 degrees and near-zero humidity. And be prepared for one of the most expensive tourist visas you will ever buy.

And a PS – What did I most regret not bringing home? A reproduction set of body armour fit for the Great Khan himself, real leather, and under $500, but needs a lot of excess baggage, and the weapons attached might get Australian Customs interested.

Landscape, Lots of rocks and no mountains.

RDMA EXECUTIVE & AMAQ COUNCIL MEMBER RETIRED DOCTOR REPRESENTATIVE

Dr Geoff Hawson

As the Retired Doctors Representative on the AMA Qld Council, I thought I would set out the following information on the changes that will/ are affecting doctors who are reaching retirement age.

My aim is to provide an overview of key issues compiled from multiple documents located on the AHPRA website. My interpretation is not infallible and members should research information relevant to their situation and practice requirements.

The Medical Board's role is to ensure that all doctors who are registered to practice have the current skills, experience and qualifications to provide safe care. There are no minimum levels, but …you must have professional indemnity to cover all aspects of your practice, and meet the Board's registration standards on Continuing Professional Development (CPD) and recency of practice.

The remainder of this article is an expansion on the following issues.

1. Definition of practice
2. Recency of practice
3. Maintenance of CPD requirements
4. Non-practicing registration (NPR)
5. Retired doctors

Medical Indemnity is important but not covered in detail here.

1. Definition of practice: - Practice means any role, whether remunerated or not, in which:- The individual uses their skills and knowledge as a health practitioner in their profession.

> For the purposes of this registration standard, **practice is not restricted to the provision of direct clinical care.**

It also includes **using professional knowledge** (whether remunerated or not) in a

1. direct non-clinical relationship with clients,
2. working in management, or administration,
3. education,
4. research,
5. advisory, regulatory or policy development roles,
6. and any other roles that impact on a. safe,
   b. effective delivery of services in the profession

2. Recency of Practice: - To meet this registration standard, you must practise within your scope of practice at any time for a minimum total of:

- four weeks full-time equivalent in one registration period, which is a total of 152 hours, or
- 12 weeks full-time equivalent over three consecutive registration periods, which is a total of 456 hours. (Note: implies that hours can vary per period as long as a total of 456 is reached across 3 periods although this is not stated)

Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours.
There are no exemptions to this standard

3. CPD Requirements

- Medical practitioners with specialist registration must continue to meet the requirements set out by their relevant college.
- Medical practitioners with general registration (who do not have specialist registration) must continue to complete a minimum of 50 hours CPD per year. This might require some form of reflective audit. This may not be the same as the recency requirements

Definition of CPD: - CPD is the means by which members of the profession maintain, improve, & broaden their knowledge, expertise and competence, and develop the personal qualities required in their profession.

There are two time hurdles for registration.

1 CPD hours – The hours required will vary according to specialist college as per 3 above. For general registration, it may be that hours accumulated for recency of practice can count towards CPD hours, although this is unclear in the standards. Practitioners will need to consider categories of professional involvement when determining allocation of hours, for example, education under Recency of Practice appears to refer to education of others (as in lectures) and not CPD self-education (by reading or attending events).

2 Recency of practice hours: Many things could be counted here, but 40 weeks of non-holiday time would require 3.8 hrs per week (average) to comply. Added to this would be the 1.25 hrs per week of CPD.

4. Non Practicing Registration (NPR): - (FAQs 29/7/2013 on AHPRA website)

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RDMA EXECUTIVE & AMAQ COUNCIL MEMBER RETIRED DOCTOR REPRESENTATIVE CONTINUED FROM P10: DR GEOFF HAWSON

1. NPR allows the use of the protected title "Medical Practitioner" BUT does not allow medical practice (see below).
2. Practitioners are subject to the Medical Board's jurisdiction in relation to professional conduct.
3. NPR has a reduced registration fee. ($141 vs $724)
4. Practitioners do not have to meet the Board's standards in relation to:-
   a. Medical Insurance
   b. CPD
   c. Recency of practice.

Under the National Law, medical practitioners with non-practicing registration must not practice the profession. You cannot provide medical treatment or opinion about the physical or mental health of an individual, prescribe, or formally refer to other health practitioners. I am not sure why anyone would choose to register under NPR as individuals cannot practice medicine in any form (as defined in section 1 above – Definition of practice).

5. Retired Doctors

Retired doctors (as defined by AHPRA):
1. Can use the title "doctor".
2. Cannot use the title "medical practitioner".
3. ***Cannot practice medicine** (as per above).
4. Pay no fee.

Summary

The Definition of Practice is broad and impacts doctors who are retired and have given up their registration, or choose to register under NPR. It is the view of the Medical Board and the AMA that medical practitioners who choose to maintain any form of practice, including writing scripts and referrals for relatives and friends must maintain a category of practicing registration and must meet the Board's registration standards.

The AMA's position is that the general registration category is the best option to allow any doctor who decides to scale back their practice, for any reason, with or without remuneration, to determine their own scope of practice.

However, practising the profession includes imparting medical knowledge. Does this mean that a doctor who is non-practising or retired should not at any time discuss any aspect of medicine or healthcare? Based on the above, one could argue the answer is "yes."

In their position statement, the AMA encourages all medical practitioners to maintain registration and CPD and notes that medical practitioners have a duty, if they continue to provide patient care, to do Continuing Professional Development (CPD).

However, the CPD requirements can be met through a wide range of activities, not all of which have to be particularly onerous.
Examples listed include attending structured educational courses to reading journals and undertaking online learning activities. Both recency and CPD requirements must be met.

Although the AMA and the Medical Board appear to be in agreement, with no appetite for changing these limitations for non-practicing-registered doctors and retired doctors, it is worth noting that the AMA Queensland Council includes a Retired Doctor Representative position, which I fill.

Not all states have this position. I will continue to use this relatively unique position to advocate for change wherever possible and I am happy to receive comments from RDMA members via the Executive.

This could be discussed at the next RDMA MTG.

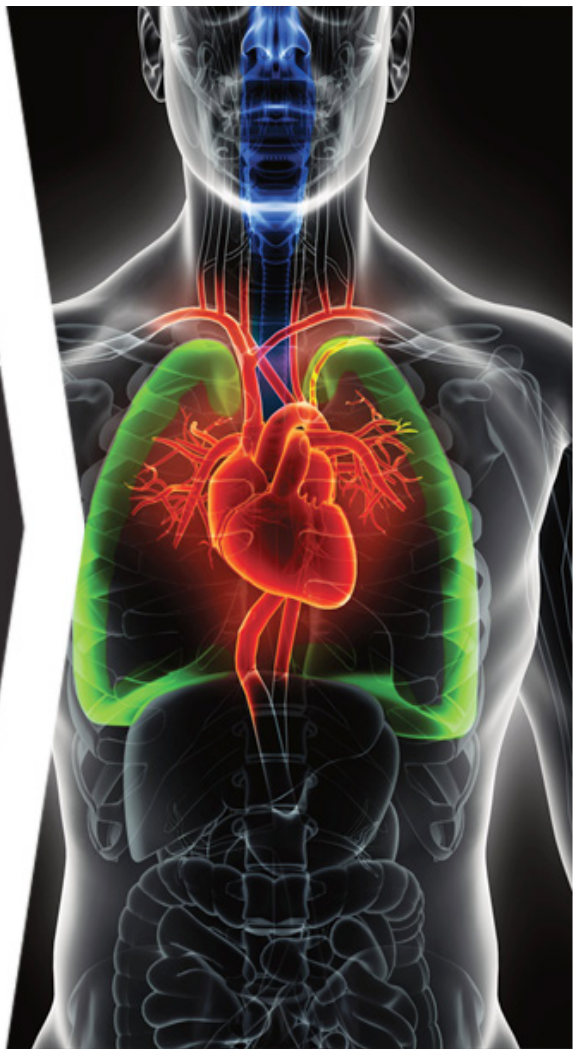
Geoff Hawson
MBBS, FRACP, FAChPM, FRCPA (1976)

RDMA executive (retired doctor representative)

AMAQ Council member (retired doctor representative)

** As the definition of 'practice' is broad, *practitioners engaging in non-clinical practice can be registered and will continue to meet this standard as long as they do not change the scope of their practice*.

However, if they wish to change the scope of their practice, for example to resume clinical activities, they will need to meet the requirements in this standard.



Interesting Tidbits NATTY MOMENTS:

When a Man Takes a Wife

When a man steals your wife, there is no better revenge than to let him keep her.
LEE MAJORS

After marriage, husband and wife become two sides of a coin; they just can't face each other, but will they stay together.
AL GORE

By all means marry. If you get a good wife, you'll be happy. If you get a bad one, you'll become a philosopher.
SOCRATES

Woman inspires us to great things, and prevents us from achieving them.
MIKE TYSON

The great question which I have not been able to answer... is, "What does a woman want?
GEORGE CLOONEY

I had some words with my wife, and she had some paragraphs with me.
BILL CLINTON

"Some people ask the secret of our long marriage. We take time to go to a restaurant two times a week. A little candlelight dinner, soft music and dancing. She goes Tuesdays, I go Fridays."
GEORGE W. BUSH

"I don't worry about terrorism. I was married for two years."
RUDY GIULIANI

"There's a way of transferring funds that is even faster than electronic banking. It's called marriage."
MICHAEL JORDAN

"I've had bad luck with all my wives. The first one left me and the second one didn't." The third gave me more children!
DONALD TRUMP

Two secrets to keep your marriage brimming
1. Whenever you're wrong, admit it,
2. Whenever you're right, shut up.
SHAQUILLE O'NEAL

The most effective way to remember your wife's birthday is to forget it once...
KOBE BRYANT

You know what I did before I married? Anything I wanted to.
DAVID HASSELHOFF

The Medical Journal of Australia • MJA
MEDIA RELEASE

GPs SET TO HAVE GREATER ROLE IN MANAGING HEPATITIS C

EMBARGOED UNTIL 12:01am Monday, 17 July 2017

The introduction of new direct-acting antivirals (DAAs) for hepatitis C virus (HCV) infections paves the way for greater GP involvement in managing the disease, according to experts writing in the *Medical Journal of Australia*.

Professor Mieke van Driel, Chair of General Practice at the University of Queensland, and colleagues from the University of Queensland and Flinders University wrote in a Perspective that capitalising on new DAA therapies will require "the concerted efforts of general practitioners to improve rates of diagnosis, assessment, treatment and follow-up in the community".

Up to 50% of people who inject drugs and 30% of prisoners have an HCV infection, while prevalence in Aboriginal and Torres Strait Islander people has increased to fourfold the rate in non-Indigenous populations over the past decade. Although preventing new cases through initiatives such as needle exchanges is important, "reducing prevalence by treating people living with HCV infection before they develop progressive liver disease is key to curbing the pending epidemic of liver failure and hepatocellular cancer", the authors wrote.

The recent listing of DAAs on the Pharmaceutical Benefits Scheme allows GPs to prescribe DAAs either in consultation with a specialist or independently once experienced. GP involvement in treating HCV is a growing trend, up from 4% of cases in March 2016 to 19% of cases in September of the same year.

The vast majority of people living with HCV are not actively injecting drugs and may not have used them for decades. They may suffer from the stigma of having an HCV infection, posing a barrier to diagnosis and treatment. Embedding HCV management in general practice could help identify these patients, facilitate initiation of treatment and improve adherence.

The authors noted that continuity of GP care also creates opportunities for monitoring the long-term effectiveness and safety of DAAs.

"Tackling HCV infection may lead the way to further innovations involving GP–specialist partnerships that bridge the existing divides to improve patient outcomes at an affordable price to society," the authors concluded.

Please remember to credit The MJA – this assures your audience it is from a reputable source

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76-HOUR SHIFT HIGHLIGHTS NEED FOR SAFER WORKING HOURS FOR PUBLIC HOSPITAL DOCTORS IN AUSTRALIA

AMA Safe Hours Audit 2016

The latest AMA audit of working conditions for doctors in Australian public hospitals shows that one in two doctors (53 per cent) are working unsafe shifts that place them at a higher risk of fatigue, with one doctor reporting an unbroken 76-hour shift.

Shifts of 72 hours, 59 hours, 58 hours, and 53 hours were also reported.

Over a one-week period in November 2016, 716 salaried doctors and doctors in training (DiTs), including 675 hospital-based doctors, kept an online diary of their hours of work, on-call hours, non-work hours, and sleep time.

AMA President, Dr Michael Gannon, said today that the 2016 Audit – the fourth conducted by the AMA since 2001 – is an improvement on 2001 when 78 per cent of those surveyed reported working high risk hours, but it is worrying that there has been no improvement since the 2011 Audit, which also showed 53 per cent of doctors at significant risk of fatigue.

"The Audit warns that the demands on many doctors continue to be extreme," Dr Gannon said.

"It is disappointing that work and rostering practices in some hospitals are still contributing to doctor fatigue and stress, which ultimately affect patient safety and quality of care and the health of the doctor.

"It's no surprise that doctors at higher risk of fatigue reported working longer hours, longer shifts, more days on call, fewer days off, and skipping meal breaks.

"We are dismayed that one doctor reported working a 76-hour shift in 2016, almost double the longest shift reported in 2011.

"It is also a great concern the maximum total hours worked during the 2016 survey week was 118 hours, the same as 2006 – no improvement in a decade."

The most stressed disciplines were Intensive Care Physicians and Surgeons with 75 and 73 per cent respectively reporting they were working hours that placed them at significant or high risk of fatigue.

Research shows that fatigue endangers patient safety and can have a real impact on the health and wellbeing of doctors.

The 2016 AMA Audit confirms that the demands on public hospital doctors are still too great.

Dr Gannon said that State and Territory Governments and hospital administrators need to intensify efforts to ensure better rostering and safer work practices for hospital doctors.

"Reducing fatigue-related risks does not necessarily mean doctors have to work fewer hours, just better structured and safer ones," Dr Gannon said.

Continued on Page 15

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76-HOUR SHIFT HIGHLIGHTS NEED FOR SAFER WORKING HOURS FOR PUBLIC HOSPITAL DOCTORS IN AUSTRALIA

AMA Safe Hours Audit 2016 Continued

"It could be a case of smarter rostering practices, improved staffing levels, and better access to appropriate rest and leave provisions so that doctors get a chance to recover from extended unbroken periods of work.

"Administrators must also acknowledge that fatigue has a significant effect on doctors in training, who have to manage the competing demands of work, study, and exams.

"The Audit found that six out of ten Registrars are working rosters that place them at significant or higher risk of fatigue, compared to the average of five out of ten hospital-based doctors.

"Public hospitals need to strike a better balance for doctors in training.

"They must provide a quality training environment that recognises that safe working hours and conditions for teaching and training will ultimately ensure high quality patient care."

The **AMA's National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors (the Code)** was revised in 2016. It provides practical guidance on how to manage fatigue, and eliminate or minimise the risks associated with shiftwork and extended working hours. This should be adopted as the minimum standard by all States and Territories.

The **2016 AMA Safe Hours Audit Report** is at https://ama.com.au/article/2016-ama-safe-hours-audit

The **AMA's National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors** is at https://ama.com.au/article/national-code-practice-hours-work-shiftwork-and-rostering-hospital-doctors

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15 July 2017

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A Mystery Called Machu Picchu

by Cheryl Ryan

Azure blue skies and emerald green hills, the mysterious ruins of an ancient civilization, pristine, serene and awe-inspiring – it is no surprise why Machu Picchu is counted among the new Seven Wonders of the World!

For the Active

If trekking and a holiday off the beaten track are your idea of a break, Machu Picchu should rank high on the list of must visit destinations. Be ready to experience a host of sensations as you make this breath-taking 99km journey from Cusco to the engineering marvel that awaits you at Machu Picchu.

A train journey combined with the entry fee to the ruins will set you back by a minimum of 150$ so those who do not mind a workout and have sufficient days in hand will find roughing it out and battling the elements worth their while, just to be able to experience the majesty of lush green alpine jungle landscape, a jaw dropping night sky with more stars than you ever saw in your lifetime and the mesmerizing historical architecture.

Soak in the extraordinary views of Machu Picchu as you walk the Inca trail, which Hiram Bingham took in 1911 to track down a hidden Inca city.

For Seekers and Admirers

If you itch to know why Machu Picchu was built and that too at a citadel with the most awe inspiring location that is almost fit for the gods, check out the practically deserted but spectacular Museo de Sitio Manuel Chávez Ballón, tucked at the end of a dirt road, about a 30-minute walk from the town of Aguas Calientes and situated near the base of Machu Picchu.

Twice as tall and located at the opposite end of the site, the Huayna Picchu summit offers birds eye views of the extraordinary architecture as well as the fast flowing Urubamba River, this coils around the site like a white snake.

Temple of Condor is a historical attraction, named on a carved head of a condor with widely spread wings.

This is just to name a few as Machu Picchu offers plenty to see and admire the cultural heritage!

We have developed the Itinerary keeping the top attractions in Machu Picchu:

Hiking and Hiking!

Even though it looks hard to climb, it is not really, believe us. Our experts take you to one of the famous climb of 90 minutes to the mountain of Wayna for you to enjoy the breathtaking views to capture from your Canon or Nikon lens. Also, the 4 day Inca Trail will satiate the hiker in you as you walk amid the gorgeous mountains, serene rivers, and forests hugged with clouds, only makes the hiking experience truly memorable!

Sacred Valley of Cusco

Our guides take you to Cusco and its popular sacred valley. Explore the Pisac and Moray ruins, to admire its cultural heritage. Now, we have access to Huchuy Qosco, a local village, which was previously bypassed for travelers.

Enjoy this hidden gem with us and make the most of your Machu Picchu holidays!

www.123Travelconferences.com.au

Improving Patient 0utcomes for Those Transitioning into Aged Care…..

In an aging population, where the number of Australians aged over 70 is expected to triple by 2050, now more than ever older Australians are urged to consider their financial future.

To avoid making quick desisions, concerning large sums of money, a clear plan for aged care will help the elderly and their families to avoid making costly mistakes, which are often followed by unintended financial consequences.

All to often a trip to the hospital, for an elderly person, will trigger their transtion into Aged Care. This is often the case when an elderly parent has a fall and can no longer return to living in their own home. All of a sudden families are caterpolted into the world of Aged Care, lost in a maze of fees, paperwork, procedures and decisions. All at a time when big decisions need to be made and families are in complete shock at the prospect of financing aged care.

Caregivers, patients, families and advocates need to consider Aged Care Solutions sooner rather than later. Statistically at aged 65 a person's chance of needing residential care during their lifetime is 68% for women and 48% for men. Therefore, the chance of an elderly person being forced into Aged Care is extremely high.

Healthcare providers play a major role in improving patient outcomes, of those transitioning into Aged Care, by encouraging patients to seek professional financial advice prior to a triggering event. Early planning and good advice can help take the stress out of Aged Care decisions. Aged Care Planning allows families to make informed financial decisions, about future care needs, without the looming presure of immediate medical treatment and a hospital discharge dates. With time to plan the below supports can be discussed and actioned providing confidence and peace of mind for elderly patients and their families.

- Help to create a clear plan for aged care;
- Provide transparency to help family discusisons and to minimise disputes;
- Evaluate options and stragegies for accommodation payments including the role of the family home;
- Identify what is important to achieve client goals and preferences;
- Review current financial situation and help evaluate affordable Aged Care options;
- Develop strategies to optimise current and future financial position;
- Review or implement an estate plan to avoid unintended consequences;

If you have aging patients, whom may require Aged Care in the future, please encourage them to seek professional financial advice. This will enable them to make informed decisions and understand the actions needed to secure residential care, should they ever need to make this transition.

Please don't hesitate to contact us if we can be of assistance on 07 54379900.

Kirk Jarrott BComm, DFP
Aged Care Specialist and Investment Advisor

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AMA FAMILY DOCTOR WEEK, 23- 29 JULY 2017

YOUR FAMILY DOCTOR: ALL ABOUT YOU

YOUR FAMILY DOCTOR:
ALL ABOUT YOU

AMA Family Doctor Week is the AMA's annual celebration of the hard work and dedication of Australia's GPs – your family doctors.

Each year, the AMA reminds the community of the vital role played by local family doctors in keeping Australians healthy.

Having a trusted family doctor is good for your health.

People who have an ongoing relationship with a family doctor are shown to have better health outcomes.

This year, the theme for Family Doctor Week is Your Family Doctor: all about you.

AMA Family Doctor Week puts the spotlight on the important role played by GPs in local communities – cities, suburbs, towns, and remote communities – across Australia.

During Family Doctor Week, the AMA will issue media releases highlighting the vital work undertaken by family doctors in keeping people healthy at every stage of life.

The AMA encourages local media to make contact with family doctors in your own, suburb, or local community to hear their stories about the joys and the challenges of providing quality health care in your area.

State and Territory AMAs can help you find local family doctors.

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Please contact:

New South Wales
Lachlan Jones, 02 9902 8113, 0419 402 955
Victoria Felicity Ryan, 03 9280 8722, 0437 450 506

Queensland
Stuart Sherwin, Sequel PR, 0403 090 914

Western Australia
Robert Reid, 08 9273 3018, 0422 553 877

South Australia
Jane Ford, 0414 539 542, or
Claudia Baccanello, 08 8361 0109

Tasmania
Georgi Wicks, Font PR, 0409 709 262

Australian Capital Territory
Peter Somerville, 02 6270 5410, 0417 047 764

Northern Territory
Fiona Thomson, 08 8981 7479, 0419 827 350

Follow all the Family Doctor Week action on:
- Twitter: #amafdw17
- Family Doctor Week website: https://ama.com.au/family-doctor-week-2017

17 July 2017

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Notice to New and Past Members

Don't waste time! Join now!

CPD Points Certificate Available

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.

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 speakers are most welcome. Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost.

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: $120.00; Oct to June: $90.00; Jan to June; $60.00; April - June: $30.00)
2. Two Family Members ($20.00 Discount each) ($200 pro rata) (Please include each person's details)
3. Doctors in Training and Retired Doctors: FREE

1. Dr _____

(First Name) *(Surname)*

Email Address: _____

2. Dr _____

(First Name) *(Surname)*

Email Address: _____

Practice Address: *Postcode:* _____

Phone: *Fax:* _____

CBA BANK DETAILS: Redcliffe & District Medical Assoc Inc: BSB 064 122 AC: 0090 2422

1. PREFERRED PAYMENT METHOD: INTERNET BANKING

2. PAYMENT BY DEPOSIT SLIP: INCLUDE your name: ie: Dr F Bloggs, RDMA A/C and Date

3. ENCLOSED PAYMENT: (Subscription Form on website, type directly into it and email)

i) Complete Form and Return: C/- QML or RDMA at PO Box 23 Redcliffe 4020

2) Or Emailing to GJS2@Narangba-Medical.com.au

RATS OF TOBRUK: Continued

http://anzacportal.dva.gov.au/sites/default/files/rats-of-tobruk-transcript.pdf

John Fleming
The English ships were from the Indian squadron. They used to come in and they would berth. There'd be two or three of them and they'd come in and park in on the stream. I can remember this particular time they came out and they had boxes of oranges which we'd never seen before, you know? And a couple of officers said "hello. What are you fellas doing here?" As it happened we had our white and blue scarves on and they said "oh despatch sides. Okay fellas, keep going".

But we had this box of oranges in the car, we had been pinching stuff. But when we got back to the camp with this box of oranges and removed them from the car in the camp, you could smell them for miles. They lasted being incognito for about two ups, you know. You couldn't keep them and hide them. Everybody smelt them. Hmmm best oranges I've ever eaten.

Bob Semple
A fig tree was a tree that was over a coral sort of foundation with a big hole underneath it. It was used for all sorts of things namely a casualty clearing station for the perimeter. Of course we got a lot of injured and casualties. It also was a headquarters at one stage and all sorts of things over its time. The three weeks we were supposed to be there, really lasted for 242 days I think, but instead was closer to 8 months instead.

Under Fire
Jim Price
I suppose the scariest part of it all, was the shelling at night. You heard the sound of the mortars and the shells when flying overhead. With others you just heard a 'whipbang' sound and you knew, that they were passing by very close. Sometimes you would hear a thud when one would hit the ground but didn't detonate. The silence was deafening.

John Fleming
After you've been there a few years you get to the stage where it doesn't worry you, cause you reckon if you're gonna get hit you're gonna get hit. But in the first place, yes, I used to be worried about it, and looking for a place to hide every time. And that went right on through there, through El Alamein, you know.

Hautrie Crick
What the Germans did, they had Alsatian dogs on top of this big tunnel where the gun was. And these dogs would give you a signal that there was people around. And that's how we couldn't get it. The Navy couldn't get it because it used to run out on rails out from the side of the cliff. And it was a bloody nuisance this gun. Anyway, they couldn't get it. It might be still there today, I wouldn't know but I still think of it as still being there.

Ernie Brough
I could smell the bullets going over my head, that's what, you could smell them. I was right up against this dugout, and they poured it out. When they stopped firing, I had one grenade and a tommy gun with 50 rounds in one magazine, and 20 in another, you see. When they stopped firing I poured the 50 rounds into that dugout where they were, and threw a grenade in on top of them, and they went real quiet. And I said, "Come on, let's go while they're thinking about it". And so I turned up, and then the next thing my mate turned up, Bert Cox from Nathalia. He come up and said "hello, hello, hello." He said, "They got you at last have they"? I had a bullet in the bum, you see.

Bob Semple
The Hurley Burley of the action and the artillery was ongoing, apart from what they call Counter Battery Fire of course. Your enemy is on you all the time with the sound ranging and flash spotting equipment, they can pinpoint you pretty smartly this way, you know. You didn't have the chance of shifting to another position sometimes, to give you a bit of a temporary break, as you can in other territory though. That was a bit hard to take. And it was our duty. I have always considered the infantry as being the backbone of the army, in my book. Our job was to give them every support we possibly could, and you stand to, no matter what.

Continued next month: