RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
JUNE 2014

Tangalooma

See the Tangalooma pictorial in our regular Where We Live And Work segments page 20. .

Located in the northern part of the Bay, Moreton Island, a short boat trip from Scarborough or Manly, is one of the world's largest sand islands. Moreton is almost completely National Park, making an excellent destination for nature lovers and famous for hand feeding dolphins in the wild, at Tangalooma's Wild Dolphin Resort, a picturesque hoiday destination.

President's Message . Dr KIMBERLEY BONDESON

Now the cooler months are coming on, we are enjoying some glorious cool days with beautiful blue skies. At least we can enjoy the beautiful weather, and try and ignore the problems and difficulties proposed by the Federal Government with its nightmare budget.

Let's look at the "success" of the Redcliffe GP Super Clinic. I was told by a local pharmacist, that they do deliver services there, and that it is now open for patients. Only one General Practitioner is working there and who also does works another two days at another clinic. This General Practitioner was poached from a local practice around the corner from the hospital.

So, I went online to find out the opening hours and details – quite intrigued by the opening of another "GP Practice" and "Pharmacy". Of note, in order to get a pharmacy license to open a pharmacy adjacent to a doctors' surgery, there must be 8 full time General Practitioners working in the practice for the government to allow a new Pharmacy License.

Online, you need to look under "The Redcliffe GP Super Clinic" (noting that there is another private GP practice locally that goes under the name "Redcliffe Super Clinic" and has for a number of years.

Up pops the government website, which states that The Redcliffe GP Super Clinic, now known as "The Moreton Bay Integrated Care Center" is now providing GP services as well as on-site pharmacy. It lists the phone number as under the Metro North Hospital & Health Services. On dialing the number, it was forwarded onto another number, which rang out.

So much for getting any information!

Well, I guess they did get it right – it is a building in the hospital grounds, all $23 million dollars and 5 stories – so it is really a Metro North Hospital & Health Service Building. But a GP super clinic? I think not. Open after-hours? Definitely not.

The Health Quality and Complaints Commission – I recently had an experience where I was contacted by The Health Quality and Complaints Commission who had received a complaint. I immediately assumed it was a medical issue, a problem with either my own clinical skills or that of one of my colleagues.

Imagine my horror, when I realised that it was from a Health Quality and Complaints Commission Assessment Officer, who had received a letter from the disgruntled family member of a patient who was supposed to have attended our practice and being ignored by our reception staff.

According to this family member, who was not present, the patient staggered into the practice and collapsed at the desk. She was reportedly ignored by the reception staff, despite being extremely distressed and collapsing across the counter.

According to the complaint, there were no other patients in the waiting room, only this distressed, collapsed patient. The complainant then went onto state that the patient, after waiting a good 30 minutes,

Continuted on Page 5

RDMA Welcomes A Message From

Dr BOB BROWN,

President Northside Local Medical Association

"Blended Payments"

Cont Page 3

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

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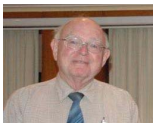

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2014 MEETING DATE CLAIMERS:

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

	Tuesday	February 25th
	Wednesday	March 26th
	Wednesday	April 30th
	Tuesday	May 27th
	Tuesday	June 24th
Next	Wednesday	July 30th
AGM:	Tuesday	August 26th
	Wednesday	September 17th
	Tuesday	October 28th Date Change
NETWORKING:		
	Friday	December 5th

DEADLINE JULY NEWSLETTER 2014
Advertising & Contribution is 16th July 2014
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INSIDE THIS ISSUE:

NORTHSIDE LOCAL MEDICAL ASSOC PRESIDENT
Dr ROBERT (BOB) BROWN

"Blended Payments"

Much has been sold about the seven dollar co-payment, very little being complimentary. Personally, I believe that it is wrong in so many ways!

However, I digress.

I have been a member of the Royal Australian College of General Practitioners for over 35 years, and have frequently questioned both its processes as well as its policies.

So, I went to the RACGP website to see what my College was saying about the co-payment. I was chuffed to see that the College opposed the payment citing some good reasons for so doing so. … However. I read on.

As part of the co-payment policy, the College alluded to a plan to look at other matters of GP funding which looked very much as proposals to work towards some form of 'blended payment'. This was despite a clear preceding statement of support for fee for service.

The 'policy' went on, requesting that the government join with the College to explore any ways in which this could progress.

For those readers who may not be aware, I was for over 10 years an AMA representative on the GP Representative Group. Together with the Department of Health and Ageing, we formed the GP Financing Group. Within the group were the AMA, RACGP, RDA and Australian Divisions of General Practice.

A great deal of work done within the group involved the Practice Incentive Payments as well as the Enhanced Primary Care Items. The position of the AMA was that these payments to General Practice were 'add-ons' and represented payments for the measurable quality of General Practices as well what was deemed to be an adequate payment for a complex episode of care in the management of complex chronic disease as well as various health assessments throughout the patient's life.

"Blended payments were not on the agenda then, nor should they be now".

I would like to know from the RACGP as to when they consulted with the membership on the Issue of 'blended payments'?

Maybe I was out of the room!

Dr Bob Brown
Presidents Report – NLMA

2014 Bi-MEETING DATE CLAIMER:

For all Northside LMA Meeting & Membership queries contact:

Meeting Convener:

Lucy Smith , QML Marketing Office,

Contact Details;

Phone: (07) 3121 4565, Fax: (07) 3121 4972

Email: lucy.smith@qml.com.au

Website and Link:

Northside Local Medical Association Website

Link: http://northsidelocalmedical.wordpress.com/

Meeting Times: 6.45 pm for 7.15 pm

2014 Dates:

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

AUSTRALIAN MEDICAL ASSOCIATION QLD PRESIDENT
Dr Shaun Rudd

Dear members,

Many years ago I joined the BMA and then, when I moved to Australia, the AMA. I joined AMA Queensland because I believed in its advocacy work on behalf of registered medical practitioners and medical students. In my time as a member, I have seen this advocacy in action as AMA Queensland has continued to promote and protect the professional interests of doctors and the healthcare needs of their patients and communities.

Now, as I begin my presidential term, I look forward to working with members, Government, and the public to support the profession and improve the health of Queenslanders.

As a general practitioner, I am aware of the negative health impacts sedentary lifestyles have on many of my patients. It is with this in mind that I have chosen to focus on lifelong exercise as a key public platform as I am passionate about the immediate and long-term physical and mental health benefits.

Another priority of mine is end-of-life care. As medical practitioners, we have a responsibility to ensure our patients have a good death as well as a good life. We need to change the attitude that ceasing treatment is a failure; rather, it is sometimes the best option to allow our patients to have a comfortable and dignified death.

To provide these patients with the best quality care, we need to support our members at all stages of their careers.

Medical students and doctors-in-training are a vital membership group. They are ultimately the future of the profession and I'm mindful of their unique concerns and interests.

This year, we have a great Council of Doctors-in-Training (CDT) that will work to ensure junior doctors and medical students are provided with training resources, professional development opportunities, and events tailored to their interests. CDT is currently working on a number of measures to support members early in their careers, such as our inaugural Junior Doctor Conference that will take place in late June.

In addition to supporting professional development initiatives, we will continue to advocate on behalf of members.

At a Federal and State level, AMA and AMA Queensland have been outspoken about the flaws in the proposed co-payment model. We are working with stakeholders to push for a better system that protects the rights of patients.

Currently, we are collecting feedback from members on how they would be affected by the proposed model. We will use the results of a short survey, distributed to GPs, Pathologists and Radiologists, to guide our advocacy work going forward.

These tasks will not be easy, but I am lucky to be supported by a committed and capable Council. We are all passionate about supporting the profession and I am confident in what we will achieve.

Sincerely,
Dr Shaun Rudd, President AMA Queensland

Kimberley Bondeson's PRESIDENT'S REPORT Continued from the FRONT PAGE:

then staggered out the front door of the practice, in an extremely distressed state, and went home.

We responded to the complainant as best as we could, apologising, with no details, and no record of the patient attending the practice that day.

That was not good enough. The complainant became even angrier, demanding that the Health Quality and Complaints Commission do something about her complaint.

Two phone calls later from the Assessment Officer, and after a lengthy report stating that we had no record of this patient attending the practice on that day, and would certainly have noticed a distressed, collapsed patient in an empty waiting room, we received a two page Early Resolution Report from the Health Quality and Complaints Commission Assessment Officer.

I find it difficult to believe that this is the type of "complaint" that the Health Quality and Complaints Commission was set up to deal with.

When I personally spoke to the Assessment Officer, she replied that this was what they considered a "Level 4 complaint". It did not involve any medical care. In fact, there are several practices along our stretch, and we may not even have been the practice that this patient attended on that day.

This is a classic example of where the government is spending its money.

Kimberley Bondeson

RDMA President

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) has left 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,
Email: PCS1@narangba-medical.com.au
Mobile: 0403 151 602.

Practice Phone & Location: Phone: 07 3886 6889, 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

VR GP required for long established Scarborough Beachfront, Non Corporate Practice, located 30 minutes from Brisbane CBD. The practice is AGPAL Accredited and is a private billing family practice with modern equipment, an experienced team of friendly GP's, RN support and administrative staff. Allied Health support is on site, QML located next door and Chemist within 20 metres.

The Centre has a Computerised Skin Cancer Clinic using DermDoc, an ultrasound machine and operating microscope with ear suction facility. Majellan is fully computerised and uses Medical Director and PracSoft packages.

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
website www.redcliffedoctor.com.au



Burpengary Family Medical Practice
BURPENGARY GP / MEDICAL CENTRE

Advertisement for full time VR GP.

Full time VR GP required in fully computerised Burpengary family medical practice in a beautiful location at Burpengary.
•Days and hours can be negotiated.
Contact: Dr.Haroon Chaudhary
Emails: mahin_saim@hotmail.com
Mobile: 0422606379
Practice Phone: 38883766

FAMILY PRACTICE MEDICAL CENTRES

FAMILY PRACTICE MEDICAL CENTRES

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

Federal Budge, AMAQ Executive, COAG Reform Council...

FEDERAL BUDGET.
It is no surprise to observe that the Federal Budget outlined last month has been unpopular. What is something of a surprise it the ferocity of opposition from an unexpectedly broad cross-section of the community. Arguably this was, to paraphrase Paul Keating's immortal words, the Budget that we had to have, an austere plan intended to reign in uncontrolled and unsustainable spending. But it is not an exaggeration to say that Federal Budget version 001 is in tatters, and we will see major structural and detailed modifications before it gets passed into law.

In the health component, the co-payment attracted most attention. My tip is that we will still see a co-payment, but that its quantum and breadth will be markedly diluted. Especially I expect to see a cluster of exemptions to maintain access to GP services by the most disadvantaged. Watch this space, because my crystal ball is no less murky than anybody else's.

AMAQ STATE EXECUTIVE.
Our State Branch has seen the handing over of power from Chris Rowan to Shaun Rudd, a GP from Hervey Bay. Chris ended his term in controversy and he was keeping a low profile for the last two months. We can expect to see more vigorous appearances from my old friend Shaun, whose Irish brogue and charm are going to attract media adulation, to be sure to be sure. The office of Chair of Council has passed to Bill Boyd, a gynaecologist from Mackay. Bill served as Chair some years ago and ran for Presidency (but there are no second prizes in politics). Council can look forward to fair and efficient conduct of meetings, and central Queensland is probably going to enjoy a higher media presence by the AMA as long as Bill has a voice there.

COAG REFORM COUNCIL.
With all the media attention on vociferous public debate over the Budget, another significant Federal initiative slipped under the radar for most health practitioners. On 30th April, John Brumby released the COAG Reform Council's report "Healthcare in Australia 2012-13: Five Years of Performance" (OK, I didn't get the title either, but I can work out that 2012-13 is not five years).
This is basically a report card on progress in provision of health services over the past five years. As a report card, it has quite a few interesting observations, a few of which I outline below. Those curious enough to read the entire report (and at 128 pages, it doesn't take a lot of reading) can find it on the Net – just Google COAG Reform Council or go to www.coagreformcouncil.gov.au.

But as a report card, it SHOULD BE most useful as a blueprint to guiding health policy for the next five years. It would be a shame if this document just gathers dust on the shelves and does not find some practical application by forward thinkers.

The bits I thought interesting (some of which are eminently well known already):
- Australians enjoy one of the highest life expectancies in the world, and we are getting even better (life expectancy at birth now 79.9 years for men, 84.3 years for women) – hey, if Australian GP's haven't being doing their job properly as Nicola Roxon once infamously said, somebody sure has
- as the AMA is fond of saying, the report confirms that "effective primary and community health help to keep people out of hospitals" – another public laurel for us humble GP's
- cancer has overtaken circulatory disease as the leading cause of death
- lung cancer has increased in women but decreased overall, and other cancer rates changed little over the five years
- the national smoking rate fell from 19.1% in 2007-8 to 16.3% in 2011-12, but COAG still aims at a rate of 10% by 2018
- Australia's rate of NIDDM compares with the developed world (well, maybe a smidgin better), but our obesity rate is sending a warning (although I think the report understates the urgency of that warning)
- half of NIDDM patients are not managing their diabetes effectively
- the cost of attending a GP was a barrier to only 5.8% of patients, compared with the cost of prescriptions being a barrier to getting scripts filled for 8.5%, and the cost of access to dental

Federal Budge, AMAQ Executive, COAG Reform Council cont: by Wayne HERDY, North Coast Branch Councillor

care was a barrier for 18.8% (rising to 25.1 for the most disadvantaged)

- patients seeking urgent access to their GP had an appointment within 4 hours in 64.1% of cases (a lot better than our general perception), but 24.1% reported that they had to wait more than 24 hours
- unfortunately, the report is silent on whether the cost of seeing a specialist is a significant barrier, and did not report on waiting times for specialist consultations
- waiting times for elective surgery increased generally, but the results varied from State to State, and cataract surgery was singled out for special negative mention
- older people seeking admission to residential care have been waiting for longer times, the proportion waiting for more than 9 months increasing from only 3.3% in 2008-9 to a massive 14.1% by 2012-13
- COAG reminds us that the growth in rates of aged care places has stalled at around 110 places per 1000 people over 70, but the Commonwealth has set a target of 125 places per 1000 by 2020-21
- potentially preventable hospital admission rates fell overall, mostly because of better community care for chronic conditions, but it is worrying that the rates of admission for vaccine-preventable conditions rose from 70.8 per 100,000 to 82.2 per 100,000.

The strongest messages for future planners and lobbyists:

- the rate of obesity is a major future health risk, especially for diabetes
- vaccine-preventable hospital admissions have risen significantly
- elective surgery waiting times are increasing, with cataract surgery earning a special mention
- the growth in rates of aged care places has stalled and older people are waiting longer to get into residential and community care places
- dental care is unaffordable
- lung cancer rates are still rising in women.

The opinions expressed in this column are, as always, those of your correspondent,

Wayne Herdy

AMAQ BRANCH COUNCILLOR REPORT GREATER BRISBANE AREA

Dr KIMBERLEY BONDESON

Copayment Implementation Process Questions...

The big issue for General Practitioners, Pathologists, Radiologists and Hospital Emergency Departments is the proposed co-payments.

No one seems to know exactly how it will work, or what it will cost the government to implement it or how the elderly, demented, homeless, disabled and other disadvantaged groups will afford it.

Even the initial author of the Article that sparked the topic, Mr Terry Barnes, who was the former advisor to then Health Minister Tony Abbott, has stated that the proposals were doomed.

How will the Triage Nurse in the Emergency Department sort out who is a "GP patient" who is attending the Emergency Department to avoid a co-payment at their local practice? How will the Triage Nurse collect $7 from patients, who turn up barefoot, with no money?

Nursing Homes and Aged Care are also affected by funding changes. It would appear that they have to go back to forcing the elderly to sell any homes or assets they have, in order to get into a Nursing Home.

They are calling this the "death payment".

What happens when that money runs out?

Can the nursing home discharge an elderly dementia patient because their money has run out? Or will they simply transfer them back to a public hospital, and then tell the public hospital they no longer have any government funded beds available?

Certainly food for thought!

Dr Kimberley Bondeson
AMAQ BRANCH COUNCILLOR
GREATER BRISBANE AREA

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 2
COST for non-members:
$30 for doctor, non-member

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.

MORETON BAY RADIOLOGY

EPIPLOIC APPENDAGITIS

Findings

A small focal area of fat stranding is seen adjacent to the distal descending colon with mild thickening of the bowel wall.

Diagnosis

Findings in keeping with epiploic appendagitis.

Discussion

• Epidemiology

This condition usually affects patients in their 2nd to 5th decades with a predilection for women and obese individuals, presumably due to larger appendices.

• Clinical presentation

Clinically patients present with abdominal pain and guarding. It is essentially indistinguishable from diverticulitis and acute appendicitis (depending on location) and although an uncommon condition, it accounts for up to 7% of cases of suspected diverticulitis. Since there is focal peritoneal irritation, pain maybe more localized than in the other causes of acute abdominal pain.

• Pathology

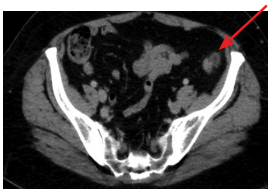
Epiploic appendagitis merely denotes inflammation of the one or more appendices epiploicae, which number 50-100 and are distributed along the large bowel with variable frequency.

. rectosigmoid junction - 57%
. ileocecal region - 26%
. ascending colon - 9%
. transverse colon - 6%
. descending colon - 2%

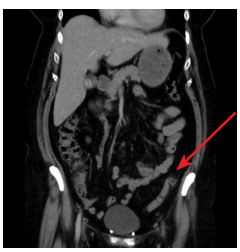
The pathogenesis is thought to be due to torsion of a large and pedunculated appendix epiploicae, or spontaneous thrombosis of the venous outflow, resulting in ischaemia and necrosis.

• Treatment and prognosis

Epiploic appendagitis is a self limiting disease, and thus correct identification on CT prevents unnecessary surgery. Although it sometimes mimics acute abdominal diseases for which surgery is required, treatment options for epiploic appendagitis often do not include surgery.



CLINICAL HISTORY: 6 days history of left iliac fossa pain, tenderness and bloating. No bowel changes. Ultrasound normal.



REFERENCES
http://radiopaedia.org/articles/epiploic_appendagitis

DIRECTOR OF REDCLIFFE HOSPITAL REPORT
DR CRAIG MARGETT

New Director of Medical Services at Redcliffe Hospital...

I am the new Director of Medical Services at Redcliffe Hospital and am offering every assistance possible to ensure GP's on the Peninsula have as much backup as they need while looking after their patients' health requirements.

I see the hospital's role as a support mechanism for GP's and their patients offering secondary and tertiary care for a short time before returning patients to their GP for long term management.

I am originally from Melbourne but have been working for Queensland Health for more than 10 years in regional hospitals including Rockhampton, Mackay and Hervey Bay.

I like the regional hospital feel and in a hospital this size I can get to know people much more easily than in a major hospital. It's easier to develop a rapport, and you can often sort things out with a conversation in the corridor.

Issues and concerns are often easily fixed by a quick phone call and I hope GPs on the peninsula will pick up the phone and call me if they need to. I am probably more accessible than our busy staff specialists and should be able to sort any problems quickly and efficiently.

There are some exciting and innovative health programs on the Peninsula which will benefit the whole community and a close working relationship between hospital and GPs is key to their success.

Chronic disease, hospital in the home and paediatric projects are just three areas where Redcliffe Hospital and general practitioners can work hand in glove to improve wellness and also reduce the amount of time patients need to spend in an acute care setting.

I'm here to help. I'm a strong believer in a collaborative, yet personal approach to solving problems, and I'm looking forward to working closely with GPs to see if together we can improve health outcomes across the board.

I can be contacted on 3883 7508 or via the hospital switchboard on 3883 7777.

Craig Margetts

How is Your Financial Fitness?

By Kerri Welsh

Are you making the most of your resources? How long is it since you assessed your Financial Fitness? Is it slowly declining or in need of CPR?

Below are a few suggestions for taxpayers to make the most of what they have:

- Wise up, knowledge is King. Surround yourself with advisors that are actionary rather than reactionary. Be armed with the knowledge that your current structure and assets are working most efficiently for you.
- Change what you do. Reinvent yourself or the services you offer. Retrain yourself or think about improvements to your products in line with consumer demand and technology advances. Do you want fries with that?
- Value You. If you are a Medico the value of YOU is in medical services, it is not in accounting services, financial planning, insurance agent etc. Surround yourself with the right people to help you so that you are free to do what you do best.
- Change how you do it. In this ever changing world there are always new ways to do things. The most recent Cloud Accounting products are fantastic and they will save you a huge amount of time whilst providing you with timely information. Xero is a excellent Cloud product and here at Poole Group we find our clients love it. You don't have to be an IT junkie to use these products, again value YOU.
- Think about what you want in Retirement. Not just the monetary amount but your lifestyle as well. So many clients I talk to say "I'm going to retire on my super". The sad truth is that a common response when asked "when did you last review your super" is "haven't looked at it in years". No nest egg or garden, if you want to use a comparison, will grow without watering, weeding, spraying, sunshine and nurturing. You will never achieve the retirement lifestyle you desire if there is no monetary super to support it. Start planning now and reviewing and re-reviewing.
- Tighten that Belt. Review all of your costs, both personal and business. Saving money doesn't always mean scrimping, it just means getting value for money. The easiest items to review are always going to be the ones that someone else reviews for you such as Insurance and Finance costs. Brokers do a fantastic job in sorting through these for you and negotiating best rates.
- Have you thought about your business exit strategy? Its best to work on a strategy at least 5 years out from your magic end date. Succession planning when done properly can yield you a superior return.
- Is your will up to date? Talk to your solicitor and update / review. Have you thought about leaving a digital legacy? www.kickthebucketlist.com is fantastic secure site to store your digital legacy.

June & July are a good time to start the financial year fresh and review your Financial Fitness. We would love to help you achieve this. If you need any help please call me on 07 5437 9900.

SNAPSHOT FROM THE PAST Divisions of General Practice
REDAMA Newsletter from Series 3 No 11 June 1992, page 11

Divisions of General Practice a concept to be welcomed

By Dr DAVID BRAND
Federal AMA General Practice Working Committee

THE concept of divisions or departments of General Practice has been around since 1984 with the release of an RACGP document titled "Guidelines for the Establishment of Departments in General Practice in Hospitals."

Their establishment has been proposed in the NCEPH paper "W(h)ither Australian General Practice?" and is a strategy supported by the NHS Issues Paper No 3, "The Future of General Practice."

In at least NSW and Tasmania, they are being established with the main emphasis being area based rather than hospital based.

Some regional health authorities in Queensland are already setting up GP reference groups and even dummy administrations for Divisions in their regions.

It is therefore important that we develop our model and ensure that it is the one, if any, that is adopted.

The concept of a Division was the single recurring theme in the various workshops at the summit: "GP - Dead or Alive."

It received broad support from across the range of GPs.

Several models have been proposed and the following outline some of the pre-requisites that Divisions should have.

Firstly, the most pressing problem facing General Practitioners, especially inner city GPs in Sydney and Melbourne, is that there are too many of them.

This needs to be addressed as the first priority.

Divisions may not directly address that issue but they would not make the situation worse.

Secondly, for us to support divisions, there has to be something in it for GPs.

General practitioners as a group suffer a severe morale problem.

Solving the manpower problem will help but this will take many years.

Improving the financial rewards will help but that will be difficult in the current economic climate.

Morale can be addressed by removing the isolation of GPs and by giving GPs more control over the total management of their patients.

This can only happen if there is a structure in pace to facilitate these solutions.

The AMA has been active in setting up regional LMAs in an effort to address some of these problems, and with some success.

For Divisions to works for GPs, we need a local group (a subdivision) consisting of all the GPs in that area.

The size of this subdivision is critical. I believe that it should be no larger an area than would encompass all the practice within it that are economic competitors.

These local groups would elect a representative for their subdivision to be on the Division Council of General Practice.

All GPs within an area would elect a Divisional Head. The Head would be part or full time, depending on work load, and answerable to the GPs.

Just as Specialist Departments are hospital-based, as that is where their work is centred, the the GP Division should be community-based, because that is where GPs work.

It is vital that the function of a GP Division be defined.

Some of the responsibilities could be broken up into three main headings:

- Administration of the "public" work GPs do, or may do.

Just as Specialist Departments administer and budget for the "public" work specialists do, so should the GP Division.

This could include the Practice Grants money, public health education and promotion.

- Supervision of continuing medical education.

Just as Specialist Departments supervise continuing and post-graduate medical education of that particular specialist group, then so should the GP Division.

This function could be administered by a Divisional Continuing Education Committee and it would naturally include the RACGP/ FMP/ PGMEC representatives and perhaps others.

The Director of the Division may delegate the chairmanship of this committee.

This committee would coordinate events and would not control either the activities or finances of the various member groups.

INCOME PROTECTION IS OFTEN OVERLOOKED

By Phil Roberts
AMAgency

A person's ability to earn income is their greatest financial asset - yet it is least protected.

How much do you need each month to meet your expenses? If your income stopped today, how long would your savings last?

Did you know the after tax cost of protecting your salary is about 1/2 of 1% of your salary?

Disability insurance is a low consumer involvement product. Low involvement products are where the consumer makes a decision without carefully evaluating the product.

Compare the interest and knowledge people gather before purchasing a television, car or computer.

They become involved in the sale and want to acquire knowledge whereas with insurance there is little interest!

Ensure your advisor professionally presents the issues to increase your involvement in the sale. This product is too important for you to be too casual.

There are about 30 companies in Australia offering Disability income insurance in the form of a guaranteed renewable policy or non-cancellable policy.

A guaranteed renewable policy cannot be cancelled by the insurance company in spite of the applicant having an adverse claims history.

If you are paying the premiums, know exactly what you will receive.

Do not wait until claim time to ask the questions!

MEDICAL CLASSIFIEDS

FOR SALE

EXAMINATION COUCH with built-in sliding cupboards (for storage). Black leather with pine wooden base. Very good condition - $570.00 ono. Phone (07) 881 2377 and ask for Practice Manager.

GENERAL NOTICES

JUNE general meeting of the Redcliffe and Districts Local Medical Association will be held at the Golden Ox Restaurant, Margate, on Friday, June 26 at 7pm. Sponsored by Boehringer Ingleheim. Acceptances to 284 6666 by Wednesday, June 24.

FREE CLASSIFIEDS are available to financial members of the Redcliffe LMA. Fax copy to (075) 91 3216.

REDAMA REPORT

Redama Report is the official publication of the Redcliffe and Districts Local Medical Association, and is distributed free to members of the medical profession in the association's designated area.

Editor: Ross Thompson, The Word Factory Public Relations, PO Box 525 ASHMORE CITY 4214.
Telephone: (075) 91 3099 Fax: (075) 91 3216.

RDMA May Meeting 27.05.2014

Chair President Dr Kimberley Bondeson, Speaker: Dr Frank Thomas Topic: Three New Techniques for Managing Chronic Pain, Sponsor: Nevro Corp

CENTRE TOP: Robert Hodge, Peta McLaren with Speaker Frank Thomas,

CLOCKWISE; Members attending the meeting.

Melissa Lee, Janice Kivieria with New Member Samir Bhagueat.

Kimberley Bondeson socialising with members at the meeting.

Sponsors & Speaker: Cathryne Nielsen, Frank Thomas, Cara Ceccatio, Mat Goldstone.

RDMA President Kimberley Bondeson and Vice President Wayne Herdy

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: **Tuesday 24th June**

Time: 7 for 7.30pm

Venue: Renoir Room - The Ox, 330 Oxley Ave, Margate

Cost: Financial members - FREE, Doctors in training - FREE
Non-financial members $30 payable at the door. (Membership applications available)

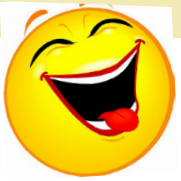
Agenda:

7.00pm	Arrival and Registration
7.30pm	Be seated - Entrée served Welcome by Dr Kimberley Bondeson - President RDMA Inc.
7.35pm	Sponsor: Experien Insurance Services & Investec Specialist Bank
7.40pm	Speaker: Craig Wright - Experien Insurance Services Topic: Life Insurance response to our Nation's Health Crisis. Speaker: Jeff Miller - Investec Specialist Bank Topic: Doctors are different. Understanding your finance options.
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 20th June 2014

QML Pathology.

Interesting Tidbits NATTY MOMENTS:



Punography

I tried to catch some Fog. I mist.
When chemists die, they barium.
Jokes about German sausage are the wurst.
Venison for dinner? Oh deer!
I know a guy who's addicted to brake fluid. He says he can stop any time.
How does Moses make his tea? Hebrews it.
I stayed up all night to see where the sun went. Then it dawned on me.
This girl said she recognized me from the vegetarian club, but I'd never met herbivore.
I'm reading a book about anti-gravity. I can't put it down.
I did a theatrical performance about puns . It was a play on words.
They told me I had type A blood, but it was a Type-O.
A dyslexic man walks into a bra and ordered a martini.
PMS jokes aren't funny, period.
Why were the Indians here first? They had reservations.
Class trip to the Coca-Cola factory. I hope there's no pop quiz.
Energizer bunny arrested. Charged with battery.
I didn't like my beard at first. Then it grew on me.
How do you make holy water? Boil the hell out of it!
Did you hear about the cross eyed teacher who lost her job because she couldn't control her pupils?
When you get a bladder infection, urine trouble.
What does a clock do when it's hungry? It goes back four seconds.
I wondered why the baseball was getting big ger. Then it hit me!
Broken pencils are pointless.
What do you call a dinosaur with a extensive vocabulary? A thesaurus.
England has no kidney bank, but it does have a Liverpool .
I used to be a banker, but then I lost interest.
I dropped out of communism class because of lousy Marx.
All the toilets in New York 's police stations have been stolen. Police have nothing to go on.
I got a job at a bakery because I kneaded dough.
Haunted French pancakes give me the crepes.
Velcro - what a rip off!
Cartoonist found dead in home. Details are sketchy.
I used to think I was indecisive, but now I'm not so sure.
Earthquake in Washington - obviously government's fault.
Be kind to your dentist. He has fillings, too.

FOR SALE
EXAMINATION COUCH

The couch is wooden with cupboards and drawers.

Proceeds of this offer will go to support the Phillipines Relief.

Also on offer are padded waiting room chairs.

For further details contact Dr Philip Dupre on Mobile: 0402 226 378

• STATE ELECTION RESULTS

Redcliffe sets a record with four on Council

A RECORD four members of the Redcliffe and Districts Local Medical Association have been elected to the Queensland State Council of the Australian Medical Association.

The election of four members gives Australia's largest local medical association two more representatives than the previous record of two, set last year.

The four are:

• Current State secretary, Dr Rob Hodge, a former LMA president and visiting specialist in the Redcliffe area;

• State councillor, Dr David Brand, a general practitioner from the Strathpine area, who is the immediate past president of the LMA;

• Current president of the LMA, Dr Bob Brown a general practitioner from the northern suburbs;

• Dr Helen Mahoney, a specialist in practice in Kippa Ring, who was secretary of the LMA for six years until 1991.

Drs Hodge, Brown and Brand are three of six representatives elected to represent Brisbane Metropolitan under a new format for the AMA which saw the state divided into zones.

Dr Mahoney was elected unopposed as the Pathology representative in the three Specialist Craft positions.

Dr Brown said the election of four members was a significant acknowledgement of the work of the Redcliffe association in medical politics, community health awareness and post graduate training.

"It is a daunting proposition to be elected to the State association at a time when general practice is in the spotlight of attention from the Federal government," he said.

"It is also significant that there will be a strong representation of pro-active, dedicated general practitioners on a State Council that has long been regarded as predominantly specialist doctors."

Dr Brown said another long-serving LMA member, Dr Tom Doolan of Kilcoy, was currently serving on a special joint committee examining the future of general practice in Australia.

Dr Brand is also a candidate for the position of Queensland delegate to the Federal AMA, to be decided in June.

Dr Michael Cohn, who launched his campaign for the position of President-elect at a Redcliffe association dinner meeting, was elected to the second highest position on the State council.

The president elect serves one year as deputy to the president before automatically taking the top position next year.

At the annual general meeting on May 22, Dr Hodge was elected as Chairman of Council, with Dr Mahoney as State Secretary and Dr Brand as treasurer.

Dr Brown said he had not be sought an executive position because he still had three months to serve as local president.

"There are plenty of experienced doctors on the council who were available," he said.

EXECUTIVE MESSAGE

By Dr ROBERT BROWN
President

THE recent success of the LMA sponsored Breast Screening Seminar at Redcliffe once again demonstrated graphically, the importance of the profession in educating the public, and our patients in particular.

Further meetings are being organised for Caboolture and the Pine Rivers, and we are very grateful to our panelist doctors who are giving so willingly their time.

We would appreciate any o f our members coming forward with similar suggestions and plans for other public awareness seminars and believe that the LMA needs to be seen to be pro-active in community education.

Our annual June Post Graduate weekend has been held at Cherrabah Resort, and was once again very successful.

Thanks must go to all who attended and especially to Drs Hool and Mahoney for their organisation of the programme.

We hope to make next year's weekend bigger and better, and preliminary discussions have already been held.

The AMA-RACGP Reference Group continues to lead the national fight for recognition of the Medical profession's right and obligation to set an agenda for the "reform" of General Practice.

The fact that the Minister for Health is unhappy with our provocative stance must mean that some success is being achieved.

We wait with baited breath for the changes which must come, both in July and in the August budget.

Don't leave it too late to talk with your patients, and keep them fully informed of what the proposed changes may mean to them!

HEALTH SYSTEM IMPROVEMENTS THREATENED BY GOVERNMENT'S BUDGET MEASURES

AMA Response to *COAG Reform Council Healthcare Performance Report 2012-13: five years of performance*

AMA President, A/Prof Brian Owler, today welcomed some notable health system improvements detailed in the COAG Reform Council *Healthcare Performance Report*, but warned that these hard-won advances could be reversed as a result of the Government's latest Budget measures.

A/Prof Owler said that there is some good news in the COAG report.

"Across the population, life expectancy, and rates of child death, heart attacks, lung cancer and deaths from circulatory disease, have all improved over five years," A/Prof Owler said.

"But the report also shows that public hospitals are already stretched to meet demand. Waiting times in emergency departments have improved (72 per cent), but have not achieved the target set by COAG (80 per cent by 2012-13).

"Elective surgery waiting times have increased nationally, from 34 to 36 days.

"Access to important surgery varies significantly by levels of disadvantage. For example, it takes 42 days longer for cataract extraction for people in disadvantaged areas.

"Our hardworking doctors and other health professionals are doing their best with limited capacity, but our public hospitals will now have to cope with the effects of the Government's Budget measures.

"The Government is reducing public hospital funding by $1.8 billion over the next four years and reneging on the guarantee of $16.4 billion additional funding under the National Health Reform Agreement over the next five years.

"The COAG report also highlights the dangers of implementing the Government's poorly-designed model of co-payments for General Practice, pathology and imaging services, and increasing co-payments for PBS medications.

"According to the COAG report, in 2012–13, 5.8 per cent of people delayed or did not see a GP due to cost.

"Over the same period, 8.5 per cent of people given a prescription by their GP delayed or did not fill it due to cost.

"One in eight people (12.4 per cent) in the most disadvantaged areas delayed or did not fill a script due to cost (36.4 per cent for Indigenous people).

"Under the Government's proposed model, there are co-payments applied at multiple points in the health system - and these are excluded from the Medicare Safety Net.

"A patient who is sick and needs tests, repeat GP visits, and medication during an episode of illness would face an accumulated financial burden.

"Overseas experience has shown this to be a significant barrier to care for people in disadvantaged groups.

"Doctors know that medication non-compliance, including not filling prescriptions, has serious consequences for health care.

"Research shows that an increase in patient share of medication costs is significantly associated with a decrease in adherence.

"The rates for not filling scripts in the COAG report can be expected to increase significantly with increased co-payments for PBS medicines. This would have serious consequences for downstream healthcare costs.

"A similar impact will occur with co-payments for pathology and diagnostic imaging services.

"With less diagnostic information, treating doctors will be hampered in their diagnosis and treatment of their patients.

"Mandatory co-payments for GP services will also affect vaccination rates, leading to complications and preventable hospitalisations for some patients. Vaccine preventable hospitalisations have increased by 16 per cent over five years.

"The good news in the report about improved health outcomes is overshadowed by the risks of the Government's co-payment model, with the potential for even more people to delay or not access essential treatment.

"This will inevitably increase costs in other parts of the health system.

"The rest of the world is lowering barriers to primary care to improve overall health outcomes and make their health systems sustainable. But Australia is moving in the opposite direction - even though our health costs are not rising relative to the total Budget.

"The Government did not consult with the profession over the design of its co-payment model – and it shows.

"The Government must scrap the current co-payment model and seek expert health advice on a better policy direction," A/Prof Owler said.

Key findings of the COAG Report include:

- a decrease in the adult smoking rate (down by 2.8 per cent from 2007-08 to 16.3 per cent in 2011-12, revision to previously reported data, p32);
- a decrease in adult risky drinking (down by 1.5 per cent from 2007-08 to 19.4 per cent in 2011-12, p10);
- an increase in adult overweight and obesity (up by 1.6 per cent from 2007-08 to 62.7 per cent in 2011-12, p33);
- an improvement in waiting times for GP services for urgent appointments within 4 hours (64.1 per cent in 2011-12, 61.4 per cent in 2009, p48). 24.6 per cent of people waited 24 hours or more in 2012-13.

Aged Care

Aged care services were largely ignored in the Federal Budget.

The COAG Report shows that larger numbers of older Australians are now waiting nine months or longer, after being assessed for services, before receiving those services. And this does not count the time they wait to be assessed for the aged care services.

AMA members are reporting long delays in obtaining aged care assessments for their patients. These older Australians are at their most vulnerable and need timely access to aged care services that meet their needs.

Diabetes

New data relating to diabetes covered in the 2011-12 report shows half (49.5 per cent) of people who knew they had diabetes did not effectively manage their condition.

Only about one in 10 people who knew they had diabetes maintained a healthy body weight.

Overall

The report lists six areas of concern:

- increasing obesity and the risk it poses of greater chronic disease, including type 2 diabetes;
- increasing rates of potentially preventable hospitalisation rates for vaccine-preventable conditions (increased by 16 per cent between 2007–08 and 2011–12) and acute conditions (increased by 11 per cent);
- elective surgery wait times have increased for many procedures Median wait times increased for 14 out of 15 selected surgical procedures between 2007–08 and 2012–13;
- many older Australians experience longer times between being approved for aged care services and receiving those services, and growth in the rate of age care services has stalled;
- one in five Australians have trouble with the cost of dental care; and
- a long-term increase in the rate of lung cancer among women.

11 June 2014

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"COAG REPORT EVIDENCE OF PUBLIC HOSPITALS UNDER PRESSURE"

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA President, A/Prof Brian Owler, said today that the latest report from the COAG Reform Council shows that no State or Territory met all their targets for elective surgery or emergency department performance in 2013.

A/Prof Owler said the report – National Partnership Agreement on Improving Public Hospital Services: Performance report for 2013 - is further evidence of public hospitals struggling to meet demand due to limited capacity.

"Australia's public hospitals continue to provide a vital service due to the hard work and commitment of the doctors and nurses who work around the clock to provide quality care, but more funding and resources are needed," A/Prof Owler said.

"This is not the time to cut public hospital funding.

The hospitals must be funded and equipped to build capacity to meet current and future demand."

A/Prof Owler said the COAG report shows that public hospitals aren't meeting the targets set by governments in their national agreement to improve public hospital services.

"In 2013, most States did not achieve their targets for seeing patients for elective surgery in clinically recommended times," A/Prof Owler said.

"No state met their National Emergency Access Target (NEAT) for treating, admitting, or discharging patients from emergency departments within four hours.

"There have been some improvements in large public hospitals, but even these improvements need additional resources to build the ongoing capacity required to continue to meet targets.

"Unmet targets are an indicator of stressed whole-of-hospital capacity.

"Without funding to build additional capacity, public hospitals will continue to fall well short of performance targets set by governments.

"Doctors working in public hospitals today know there has been little change in the capacity of public hospitals to meet the demand for elective surgery and emergency care.

"The public hospitals will now face further stress from Government's Budget measures to reduce public hospital funding by $1.8 billion over the next four years, and withdraw the guarantee of $16.4 billion additional funding under the National Health Reform Agreement over the next five years."

20 June 2014

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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

TANGALOOMA

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