RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
JUNE 2018

"Guess You'll Be Thinking I've Gone Up In Smoke".

https://www.awm.gov.au/articles/blog/remembering-kathleen-neuss

See Where We Work & Live on page 20.

President's Report Dr Kimberley Bondeson

What delightful cold days and blue skies we are experiencing at the moment. A maximum temperature of between 20-23 degrees. We have not had a winter like this for many years. School holidays are about to start (again) and the year is slipping away. University students are preparing for midyear exams.

The automatic sign up for the My Health Record is fast approaching. My Health Record is the new name for the Patient controlled Health Record. The current plan is that all patients will be automatically signed up to MHR, without their consent after December.

Subscribers (the patient) will automatically have a MHR, which they have to "opt out of" if they do not want it. Any opting out needs to be done by the patient themselves, navigating through their MyGov account.

Information from for example Pathology and radiology providers will automatically be uploaded by default, whether you want it or not. Any health provider, pharmacist, podiatrist, and doctor can access your medical records and have a look. This program has cost more than $1 billion in taxpayers' money over the past six years.

Many doctors remain sceptical about the clinical usefulness of a My Health Record, which is patient controlled, and certainly, I am not convinced about the value for money.

Good news for General Practitioners, the RACGP's unpopular, controversial mandatory self-reflection activity (PLAN) is likely to be reversed later next month, after the college's presidential elections are held.

The 3 candidates for the next RACGP president are promising to make it voluntary if elected. It was initially introduced with little consultation with the profession, in order to persuade the Medical Board of Australia not to introduce a revalidation regiment for General Practitioners.

However, its introduction has resulted in people leaving the RACGP college.

The Health Care Homes concept seems to be dying a natural death. According to Australian Doctor (1 June 2018), 180 GP practices signed up to become Health Care Homes, receiving annual block payments from the government to fund care for patients with multiple chronic diseases. (a Capitation Model, not the Fee for Service Model which we currently have).

The government envisaged that 65,000 patients would be recruited, but only around 2000 actually enrolled.

Let's continue to see what unfolds in the medical political arena. And hope that this year's flu season is not a repeat of last years.

And enjoy the winter weather!

Kimberley

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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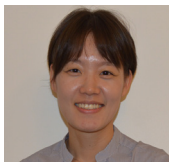

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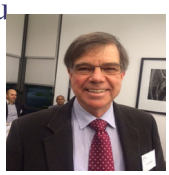

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RDMA 2018 MEETING DATES:

For all queries contact Emelia Hong 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	27th
Wednesday	March	28th
Tuesday	April	24th
Wednesday	May	30th
Tuesday	June	26th
Wednesday	July	25th
ANNUAL GENERAL MEETING - AGM		
Tuesday	August	28th
Wednesday	September	12th
Tuesday	October	30th
NETWORKING MEETING		
Friday	December	7th

NEWSLETTER DEADLINE

Advertising & Contribution 16 July 2018

Email: RDMANews@gmail.com

W: www.redcliffedoctorsmedicalassociation.org

NLMA 2018 MEETING DATES:

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	13th
2	April	10th
3	June	12th
ANNUAL GENERAL MEETING - AGM		
4	August	14th
5	October	9th
6	December	11th OR 14th

Next Meeting Date 26th June 2018

RDMA Meeting for 30.05.18

Dr Bondeson, RDMA President Introduced the Speaker:

Speaker
Dr Sanjeev Ranjam Specialist Psychiatrist/ General Adult Psychiatristh, Pine River Private Hospital.

Topic " Managing Anxiety Disorders - Common Pitfalls adn How to Address Them".

Sponsor: Pine River Private Hospital representatives were Julie Huntington and Robyn Carrington.

Photo:
Speaker Dr Sanjeeve Ranjan (Psychiatrist) with Julie Huntington (Allied Health Manager) and Robyn Carrington (Marketing Co-ordinator)

New Members in attendance were:
Dr Subrat Mishra (The Family Practice at Burpengary)

And

Dr Susmita Mishra (The Family Practice at Kallangur)

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 26th of June 2018**

TIME: 7pm for 7:30pm start

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: Bayer Australia Ltd
7:40pm	Speaker: Dr Ryan Maxwell, Cardiologist with sub-speciality training in adult congenital heart disease and echocardiography/ Prince Charles and Redcliffe Hospitals Topic: "Updates in Cardiology and Interesting Cases"
8:00pm	Main Meal served
8:20pm	Question Time
8:30pm	Dessert, Tea & Coffee served
8.40pm	General Business

RSVP: By Friday 22nd of June 2018
(e) RDMA@qml.com.au or 0413 760 961

INSIDE THIS ISSUE:

Competitive Advertising Rates:

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The preferred A5 size is Landscape Format. and A4 size is in Portrait Format.

Please note the following discounts:

- **10% discount for 3 or more placements**
- **20% discount for 11 placements (1 year)**
- **Payments required within 10 working days or discounts will be removed unless a payment plan is outlined at the outset.**

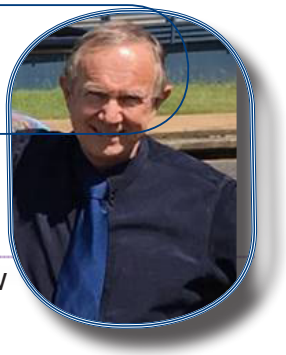
CLASSIFIEDS

All classifieds subject to the Editor's discretion.

- **No charge** to current RDMA members.
- **Non-members $55.00**

If you would like to advertise in the next month's newsletter please email RDMAnews@gmail.com in one of the preferred formats (either a pdf or jpeg). Advertisers' complimentary articles must be in the same size as adverts. Members Articles are limited to an A4 page with approximately 800 words.

AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor
AMA National Conference, MyHealthRecord, AMA Awards



AMA National Conference takes place in May every year. It is supposed to be the policy showpiece of the Federal organisation, as well as the AGM (a tedious but necessary part of any corporation) and the election of office-bearers.

The impending implementation of MyHealthRecord featured heavily in the presentation by Greg Hunt, the Minister for Health. It also featured in the soapbox day. MyHealthRecord, the shared e-health record, has been a long, long, time in its gestation. I recall being on a federal committee haggling over electronic prescribing more than a decade ago, and it still hasn't really happened. The model will be an opt-out choice, so everybody is automatically included unless they make a choice to stay out. My view is that people who have something to hide – especially doctor shoppers and addicts and patients with socially nasty conditions like STD's and mental health disorders – will opt out. The government hopes to have 75% of GP's and hospitals involved by the end of 2018, a pretty big aim.

The Minister's speech was heavy on what he calls the third wave of reform. He has a focus on workforce, a refreshing attention to primary care and PBS reform. His vision includes paying real attention to mental health and aged care, his workforce reform is paying special attention to the rural health workforce, aiming to teach train and retain doctors in the rural and regional centres. It sounds as if somebody is finally paying more than lip service to delivery of health services in the community and meeting the needs of the small end of town. Let's hope that the words turn into real action where it is needed.

Looking to the future, one of the Minister's priorities was in the mental health of the medical workforce, which he recognizes as being challenged and under stress. While he confirmed that there will be an end to mandatory reporting, I was left with the sort of uneasy feeling that comes when a politician promises something good. I have been around the political woods long enough to suspect that some bureaucrat will turn the dream into a nightmare. If the minister is promising that his department will address issues of mental health in doctors, some Canberra committee is going to impose conditions on doctors' practising rights. Already there is talk about cognitive testing in doctors over 70 years of age. Will we start seeing surveillance of doctors' moods and random drug testing? Pardon my paranoia, but we have seen this brave new world go wrong before.

Of the many NatCons I have attended (I think 18 so far) this was the best. What was new was the format of the policy sessions. Historically, NatCon plenary sessions have been designed around gathering sets of talking heads to tell us what they think the AMA should be doing. This year, the whole day was a soapbox session. Members had the opportunity to raise issues of concern, which attracted debate, and yielded a trove of motions inviting Federal Council to follow up those concerns. Instead of having a panel of external experts telling the AMA how to develop policy in the coming year, we had members bringing up problems from the grassroots, and other members giving opinions for and against.

National Conference is advisory to Federal Council. It is the Fed Council that creates our policy documents, and then pursues them through the corridors of power. But at least our lobbying campaign in the coming year is more likely to be guided by a clear indicator of what is important to the members.

In the soapbox, what stood out? Bullying in the workplace! Workforce maldistribution (the speaker believes, as I do, that there is no doctor shortage – they are just not working where they are most needed). The end to the rebate "ice age" (and pathologists reminding us that they have been frozen much longer than anybody else). Futile care in the aged care environment (a favourite of mine, because I see nurses sending dying patients to emergency departments instead of letting them depart the world in peace).

AMA AWARDS.
I would like to see AMAQ pick up more State awards at NatCon next year. Within my own area of interest, I see at least three opportunities for AMAQ to pick up awards for public health initiatives and/or lobbying campaign.
(A) Hepatitis C treatment has now fallen into GP province since the advent of the newer classes of direct-acting anti-virals (DAA's). Disappointingly, GP's Australia-wide have not been keen to adopt HCV treatment with much enthusiasm. Two of the DAA manufacturers are approaching a small number of GP's like myself (I have many drug addicts, hundreds of patients with HCV, and over 100 patients who have completed treatment) to conduct small-group training to encourage clusters of

Continued Page 9

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Building a Professional Performance Framework.

A recent 3 year study on the UK's revalidation program has shown that scheme is not meeting its goals. Whilst the UK model has not been adopted in Australia, the Medical Board in Australia is working towards adopting a policy of competency checks for doctors in the 70 plus age group and those who practice in isolation. Interestingly, this does not appear to have been in consultation with the profession.

An entire document, entitled "Building a professional performance framework" has been put forth by the Medical Board of Australia. The document states "As it implements the Professional Performance Framework, the board will consult…."

It certainly appears as a forgone conclusion that this revalidation model, renamed "Professional Performance Framework'' will be going ahead. As yet, I have not seen any consultation with the profession.

In fact, most doctors are unaware that this is looming and already put forth as a Professional Performance Framework, instead of the word "Revalidation", with the expectations by its authors at the Medical Board that it will progress into fact.

In the Medical Board of Australia documents, "Building a Professional Performance Framework", this document states in Appendix A "The Medical Board of Australia has accepted all of the recommendations made by the Expert Advisory Group on Revalidation in its final report and has developed a proposed Professional Performance Framework to implement the recommendations…."

Of particular concern are the following:
"The MBA should require all registered medical practitioners to prepare a Professional Development Plan (PDP) that is relevant to their scope of practice for each CPD period"

"The MBA should no longer recognise self-directed CPD undertaken outside an accredited CPD program." – I cannot see how this possibly is in the best interests of medical practitioners, who go above and beyond sourcing specific training and updating of skills, to no longer recognise this self-directed CPD.

And so the document goes on, and on. It also targets Doctors over 70yo, and has set a requirement that doctors at 70 years of age and every 3 years thereafter to undertake a health check, which includes cognitive screening using a prescribed validated screening tool, and to undertake a formal managed performance review process with feedback.

Professionally isolated practitioners are also targeted, expected to direct 25 percent of unallocated CPD activities towards managing identified risk from practice context. This includes performance review, peer review, peer visits and so forth.

Some of this document contradicts itself, by stating that you cannot use your self-directed CPD, but are expected after the age of 70yo, to manage your own identified risk from practice context.

This looks to me like we are going into a controlled, slavish arena, completely taking away doctors autonomy.

Sincerely

Kimberley Bondeson

QDHP Queensland Doctors' Health Programme | DHAS(Q) Doctors' Health Advisory Services

24/7 HELPLINE 07 3833 4352
For doctors and medical students only

The Doctors' Health Advisory Service of Queensland was founded in 1989 by a group of doctors who recognised the need to assist their colleagues in difficulty. It became apparent to them that doctors often failed to access timely healthcare and treatment despite and sometimes because of working in the medical profession. Doctors frequently continued to work while unwell to their own personal disadvantage. They experienced shame, and significant difficulty taking the step to consult their colleagues.

Since then, the DHAS(Q) has regularly relieved the distress of doctors suffering sickness, helplessness, disability and misfortune, while recognising the direct benefit to the community in providing this service.

The DHAS(Q) is a not-for-profit charity association supported by volunteer general practitioners who provide their time, expertise and service at no cost. Every day of the year, 24 hours a day an experienced GP with an interest in doctor's health is available for phone support for Qld doctors experiencing a health issue.

Some on call GPs will be retiring in the future, many having volunteered with DHASQ for over 2 decades. We are looking for GPs who are interested in doctors' health and would like to be involved in the wonderful work DHASQ provides to contact us. We have a training evening in July where you can find out more about being a DHASQ on call GP. If you are interested please send an email to president@dhasq.org.au.

Our website is http://dhasq.org.au/

ARE YOU A BULLY?

by Mal Mohanlal: Continued Page 9

Who or what is a bully? In my mind, a person who tries to make himself or herself feel superior to another human being by exercising his or her power and influence because of that person's perceived physical or mental weakness can be regarded as a bully.

Bullies exist everywhere at all levels in every society wherever you go and it can take the form of physical or mental abuse. This is because not everyone is confident about themselves and in their own abilities. Some people are basically lacking in some finer attributes such as positive self-image and they feel the need to assert themselves on a fellow being who they think is unlikely to retaliate. It is an ego boosting exercise they indulge in consciously or subconsciously because we live in a world that is very competitive and self-centred and where hierarchical structures are ingrained in every society.

A bully is basically a coward because he or she usually hides behind wealth, power and position or any label that makes one feel important.

Bullies also like to hide behind anonymity. Recently I observed in the "6 Minutes Medicine" a medical forum publication on the Internet, the writers who wisecracked and made derisive comments on the articles and people who commented on them, all disappeared after the editorial policy changed to publication of full names of all commentators. No more name initials or nom de plume were allowed. This I thought was a brilliant move to bring dignity to a worthy medical publication.

A bully will try to get at you physically or mentally to make you feel inferior or worthless. He might pick on your race, religion, colour etc. You might get called all sorts of names etc. However it is the way you react to the bully that will encourage or discourage his or her behaviour.

Now if you feel offended and affected by the bully's action, he will be sure to interpret it as a success in his approach because that is exactly what he has set out to do.

My advice to any person who is being bullied is not to give the bully the satisfaction that he or she is succeeding. You have to react in a way that does not give the bully that satisfaction. You have to learn to greet the bully each time in a friendly manner without showing any offence with equally offensive name, and walk away.

Once you can master your own reaction to the bully's action, and respond in the way I have described, you will be amazed to find a positive transformation in your relationship with the bully.

Because it is an ego orientated exercise, what bullies don't like is public exposure. So if you are being bullied and you keep it to yourself, you are only inviting more problems for yourself. What you should do is never take things lying down. What you should do is devise ways and means to counteract the bully's action and expose his behaviour to other people around you. You may even have to go to an higher authority if that is necessary. The main thing is to get your message across that you will be not walked over by any means.

Sitting by yourself and suffering in silence is not going to help you solve your problem. You have to realise that it is you who has power to change a person's behaviour with your own action.

Consumerism is distorting peoples' perceptions and one can see people are becoming more and more self-centred and intolerant. In consumerism the customer is always right. One panders to the desires of the individual ego, so that one grows up thinking that one has every right and no responsibility. Clearly one can see the decline in moral, ethical and religious influences. No one wants to accept responsibility for their own actions anymore and there is little consideration for the feelings of our fellow beings.

Politicians talk about law and order but all they are interested in is buying votes from the public by appealing to their selfish base instincts. Yes they are very good at making laws. They think that by making laws they will bring about law and order in society. How naive can one get? They should know that the fundamentals in bringing about law and order have to be laid in the early developmental stages of life. If we have no discipline in the home and in the classroom how can we have law and order in society?

Values of how to behave and consideration of other people's feelings have to be taught at home and in the classroom. Children are not born knowledgeable; they have to be taught these values. It seems parents and teachers have abandoned their responsibilities and the state laws are not helping them. One can see violence and aggressive behaviour increasing in society. There is youth violence, domestic violence, and criminal activity on the rise. Law and order is breaking down. When there is youth violence we have to use violence to restrain them,

AMAQ BRANCH COUNCILLOR REPORT Continued from Page 5
Dr Wayne Herdy, North Coast Councillor

other GP's to increase the uptake rate of DAA's and reduce the incidence of active HCV in the community. If AMAQ were to facilitate this (because doctors are suspicious of approaches by drug companies and LHN's have been slow to take advantage of the opportunity) we might claim credit for reduction of HCV in Queensland.

(B) Opioid addicts seeking community-based treatment meet a barrier of lack of resources even if they can identify a prescriber. Most patients on QOTP (Queensland Opioid Treatment Programme) are under public prescribers at AODS clinics. The manufacturer of buprenorphine (Indivior) has initiated a programme which under a thin disguise is intended to utilize prescribers like myself to teach other GP's the basics of OST (opioid substitution treatment). Increasing the number of prescribers, even if each only takes a small number of patients, will reduce opioid misuse and reduce waiting times for formal treatment, and enhance access in rural and remote areas. Again, GP's are suspicious of approaches from drug companies, and the AMAQ could facilitate a wider pool of QOTP prescribers.

(C) Prisons in Queensland have not been keen to have QOTP prescribing and dispensing in the custodial environment. Women's prison does offer QOTP, but the programme has been trialled sparingly in the men's prisons. I understand that the evolution of government policy has been toward increasing QOTP prescribing in prisons. If AMAQ were to lobby for universal opportunity for Suboxone dosing in prisons, and if that were to be implemented, then AMAQ could get national credit for a policy change that is likely to take place anyway. [I'll explain the reason for Suboxone later if AMAQ expresses interest.]

(D) I have been conscripted by MRQ (Medicines Regulation and Quality, the old DDU) to be a consultant on a working party to revise a section of the S8 prescribing regulations. I am not sure how this is going to progress, nor what the outcome will be, nor the degree to which I will be bound by confidentiality, but there is potential for this to gain credit for AMAQ as a lobbying endeavour. Watch this space.

Wayne Herdy

ARE YOU A BULLY?
by Mal Mohanlal:

but we are not allowed to discipline children when they misbehave when they are little. Discipline (violence) is not permitted because it is supposed to be psychologically harmful and bad for them. How naïve and contradictory can one get? It means that it is not okay to use 'violence' (discipline) against children when they are little but it is okay to use violence when they are older.

What is our government's response to all this bullying, increase in social violence and criminal behaviour? Do you think making more laws and increasing penalties are the answer? Do you think building more and more prisons is the answer? Do you think increasing the numbers in our Police Force is the answer? Quite clearly these are patch up jobs. It is like trying to shut the gate after the horse has bolted.

Unless our politicians can start addressing the issue of how parents are managing and coping with the early formative years of a child's life and devise ways and means of helping them, I can foresee more problems ahead for society. There are a lot of dysfunctional families in society and they are increasing. They are going to produce more and more dysfunctional children. They need help.

The fundamentals of law and order are created in the first five years of life where positive or negative perceptions are created and developed, and conditioning takes place. If we ignore this fact and do nothing about it, society must prepare itself for a more violent future. At present we are indeed living in a Fool's Paradise, where everyone has rights and no one seems to have responsibility. Yes, unless we are aware of it, without consideration for the feelings of our fellow beings we all have the potential to turn into a bully.

Bullying is a problem of perception. Playing the role of a victim is also a problem of perception. I would earnestly hope that people who are experiencing this trauma will read "The Enchanted Time Traveller – A Book of Self-knowledge and the Subconscious Mind" to help acquire some self-knowledge and change their perceptions. Visit Website: http://theenchantedtimetraveller.com.au/

Dr Dilip Dhupelia,
President AMA Queensland
and
Jane Schmitt,
CEO AMA Queensland

2018 State Budget – What it means for health

On 12 June, the State Government delivered the 2018-2019 Queensland Health Budget, which outlined a broad range of initiatives across the health portfolio. We are pleased to say that, due to the strength of our advocacy, the Queensland Government has delivered on a number of our recommendations in this year's Budget. These include:

- Establishment of the Healthy Futures Commission
- Increased funding to the OHO to improve the current inefficiencies of the complaints system in Queensland for patients and doctors
- Referral tracking system which will allow GPs to track their patients referrals in the public health system

While we welcome these initiatives, there is always more work to be done to secure the future of our medical workforce and improve the health care we deliver patients.

Office of the Health Ombudsman

AMA Queensland has advocated strongly for several years for improvements in the triaging of complaints and compliance with legislated timeframes in the Office of the Health Ombudsman (OHO). We note the Government boosted funding to the OHO by $8 million in the State Budget and, while this may be necessary, improved triaging and compliance with timeframes are key elements to ensure a more efficient and fairer complaints system. We look forward to working closely with the new Health Ombudsman Andrew Brown to significantly improve the complaints system for doctors and patients.

Public Health: Health Futures Commission

AMA Queensland is pleased the State Government has adopted our recommendation to establish a whole of government approach to public health issues, via their proposed Healthy Futures Commission, which we understand will have a particular focus on reducing the obesity epidemic in Queensland.

We encourage the Queensland Government to support AMA Queensland in our effort to have obesity defined as a chronic condition in its own right by the Federal Department of Health, rather than a just risk factor. This would allow General Practitioners to use obesity alone as the basis for providing patients with coordinated care utilising appropriate allied health workers as part of a GP Management Plan and Team Care Arrangement.

Rural Health:

We look forward to two key State Government initiatives to help rural doctors and their patients:

- **$84.8 million** as part of the Enhancing Regional Hospitals Program, for upgrades of the Hervey Bay and Gladstone emergency departments, redevelopment of Roma Hospital and repurposing of the Caloundra Health Service.
- **$53.3 million** for projects as part of the Rural and Regional Infrastructure Package across Queensland, including in Blackall, Kingaroy and Maryborough.

Doctors Mental Health

It is disappointing that AMA Queensland's request for funding to expand its mental health program to all junior doctors was not included in this year's Budget. In 2017, AMA Queensland rolled out the *Resilience on the Run* program at 21 Queensland hospitals to 633 interns to support their mental stress and emotional demands as they transitioned from medical school to the workforce. Extending the program beyond the intern years to PGY2 through 5 would have been a strong indication that the Government was willing to invest in individual clinicians - to increase their wellbeing and to better prepare them for their roles within the health system. We will continue to advocate on behalf of our members to ensure medical staff receive the appropriate support, throughout their careers, to deal with the challenges of the medical profession.

Health Budget at a glance:

- $17.3 billion operating budget for the health system - up more than $700 million
- Increased funding of $570.8 million over six years starting from 2017-18 to enhance public hospital capacity and services in the South East Queensland growth corridor, including for redevelopments at the Logan, Caboolture and Ipswich Hospitals.
- Increased funding of $50 million in 2018-19 to replace essential medical equipment such as computed tomography (CT) scanners, magnetic resonance imaging (MRI) scanners and surgical equipment
- $28.1 million for adolescent mental health facilities in South East Queensland, including a new Adolescent Extended Treatment Facility at The Prince Charles Hospital in Brisbane
- $2.5 million to continue to support bariatric trials
    - Development of an integrated referral management system which would allow GPs to track referrals of their patients through Queensland public hospitals

Dr Dilip Dhupelia, President AMA Queensland **Jane Schmitt**, CEO AMA Queensland

MEDIA RELEASE

31 May 2018

New President Fights for a Fair Go for Regional Queenslanders

Dr Dilip Dhupelia has been elected new AMA Queensland President and Dr Michael Cleary new Vice President.

Dr Dilip Dhupelia is the Director of Medical and Clinical Services for Queensland Country Practice, Queensland Rural Medical Service for Darling Downs Hospital and Health Service and works as a part time GP in Toowong in Brisbane's inner west.

Dr Dhupelia has a particular interest in rural and remote health issues having worked for many years in regional areas.

Dr Dhupelia said urban patients have access to a broad range of health services and technological advances more quickly than those in regional and remote areas.

"Regional Queenslanders deserve healthcare of a similar standard to that enjoyed by city residents," Dr Dhupelia said.

"There is no lack of medical graduates, but too few of them choose to practice outside the South-East.

"There has been significant bipartisan investment in Queensland to support rural doctor training over recent years but this investment now needs to equate to a more equitable distribution of Specialists, Rural Generalists, General Practitioners and health workers to meet the community need of almost one third of Queensland's population.

Dr Dhupelia said it was not only important to encourage young doctors to work outside the South East, but also essential to provide more support for the families of these doctors who decided to relocate to regional and rural areas.

Dr Dhupelia said he would also advocate for certainty of post graduate training for our junior doctors so that the workforce maldistribution can be addressed.

AMA Queensland's new Vice President Dr Michael Cleary is an Adjunct Professor at the University of Queensland and has more than 30 years' experience in the health sector. Dr Cleary works in a leadership role as the Executive Director of the Princess Alexandra and QE II Jubilee Hospitals in Brisbane.

Metro North **GP Alignment Program**

MATERNITY WORKSHOP

SATURDAY 28 JULY 2018

Skills Development Centre, Level 5, Block 6, Royal Brisbane and Women's Hospital

ABOUT THE WORKSHOP

The GP Alignment Program is an award-winning* series of free workshops hosted by Women's and Children's Stream, Metro North Hospital and Health Service.

The six hours of education for the **maternity program** covers a number of important topics including:

- first trimester presentations
- recommended screening tests
- ultrasound scanning including nuchal translucency recommendations
- diabetes in pregnancy
- prescribing in pregnancy
- communication with Metro North birthing facilities
- models of care options
- Rh-negative women
- early pregnancy bleeding
- reduced fetal movements
- immunisations
- hypertension
- pre-eclampsia
- depression
- postnatal care
- breastfeeding
- DVT prevention.

PRESENTERS

Presenters/facilitators include staff specialists in obstetrics and gynaecology, general and obstetric physicians, radiologists, pathologist, psychiatrist, paediatrician, maternal fetal medicine specialist, pharmacist, physiotherapist, dietician, social worker, lactation consultant, midwives, nurses and GPs.

By registering, you agree to participate in the full program, including completion of a predisposing and reinforcing activity.

Closely aligned with Mater Mothers Maternity GP Alignment Program and Queensland Health Maternity GP Alignment Programs.

SPONSORS

This event is sponsored by Sullivan Nicolaides Pathology, Cardinal Health and i-Med Radiology/Sogi Scan.

QI&CPD Accredited Activity CATEGORY 1

RACGP Accredited
Cat. 1 QI&CPD Accredited Activity
(40 points)

WORKSHOP DETAILS

Date: Saturday, 28 July 2018

Venue: Skills Development Centre
Level 5, Block 6
Royal Brisbane and Women's Hospital
Herston, Brisbane

PROGRAM

8am	Registrations open and optional tour of Women's and Newborn Services
9am-5pm	Workshop (catered)
5pm	Workshop concludes

RSVP: Please complete and fax to 07 3630 7855 or email administration.integration@brisbanenorthphn.org.au
There is no cost to register and dinner will be provided. Registrations will close Tuesday, 24 July 2018.

GP name..... RACGP No .....

Practice.....

Contact phone ..... Contact email.....

Diet or access requirements .....

I will attend the tour of Women's and Newborn Services: ☐ Yes ☐ No

For all enquiries, please contact Denise Spokes on 07 3646 4421 or email mngpalign@health.qld.gov.au

This is a joint initiative between Metro North Hospital and Health Service and Brisbane North PHN

*2015 MNHHS Staff Excellence Awards – Highly commended – Excellence in Clinical Education and Training
*2016 Queensland Health Award for Excellence – Highly commended – Connecting Healthcare

SOGI SCAN · i-MED Radiology Network · CardinalHealth · Sullivan Nicolaides Pathology · phn Brisbane North · Queensland Government

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AMA CALLS FOR HAZARA MAN TO BE BROUGHT FROM NAURU FOR PALLIATIVE CARE

The AMA today called on the Federal Government to bring an Afghan refugee with advanced lung cancer from Nauru to Australia for palliative care.

AMA President, Dr Tony Bartone, said the AMA understands that the required treatment is not able to be provided on Nauru and that the 63-year-old man, known as Ali, should be moved to Australia.

"Ali is a member of the persecuted Hazara minority in Afghanistan and has been formally recognised as a refugee," Dr Bartone said.

"He has advanced lung cancer. He needs significant palliative care services that he cannot receive on the island. This is not in dispute.

"The Australian Border Force has offered to transfer him to Taiwan. But this is not an appropriate management option. There is no Hazara community in Taiwan, he has no friends or family there, no-one to translate from his language, and no-one to perform the Shia Muslim rituals after his death.

"The AMA has always held that all people who are under the protection of the Australian Government have the right to receive appropriate medical care without discrimination, regardless of citizenship or visa status.

"They should be treated with compassion, respect and dignity.

"On any score - international obligations, conventions, respect, standards of clinical and ethical care - we must not fail to provide the requisite medical care on Australia's watch.

"The AMA reiterates its call for the establishment of a transparent, national statutory body of clinical experts, independent of government, with the power to investigate and report to the Parliament on the health and welfare of asylum seekers and refugees in Australian care.

"The AMA welcomes the appointment of Dr Parbodh Gogna as the Australian Border Force's new Chief Medical Officer and Surgeon General, and is seeking a meeting with him as soon as he starts in the role.

"In the meantime, we call on the Minister for Immigration and Border Protection, Peter Dutton, to intervene to ensure that this man receives the care he needs, in a compassionate, timely, and respectful manner."

The AMA *Position Statement on Health Care of Asylum Seekers and Refugees* is available at https://ama.com.au/position-statement/health-care-asylum-seekers-and-refugees-2011-revised-2015

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19 June 2018

CONTACT: Maria Hawthorne 02 6270 5478 / 0427 209 753

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Egypt
by Cheryl Ryan

Home to one of the most marvellous historic monuments on the planet, Egypt is a land of fascination.

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- Learn the process of turning the deceased into mummies in the Mummification Museum.
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AMA WELCOMES NATIONAL MALE HEALTH STRATEGY

The AMA welcomes today's announcement of the establishment of a 10-year National Male Health Strategy that will target the mental and physical health of men and boys.

The AMA called for a major overhaul of men's health policy in April this year, including a new national strategy to address the different expectations, experiences, and situations facing Australian men.

AMA President, Dr Tony Bartone, said the AMA was pleased that the Federal Government recognised that Australian males have poorer health outcomes, on average, than Australian females.

"In Australia, men have a life expectancy of approximately four years less than women, and have a higher mortality rate from most leading causes of death," Dr Bartone said.

"Australian men are less likely to seek treatment from a general practitioner or other health professional, and are less likely to have the supports and social connections needed when they experience physical and mental health problems.

"An appropriately-funded and implemented National Male Health Strategy is needed to deliver a cohesive platform for the improvement of male health service access and men's health outcomes.

"This does not mean taking funding away from women's health strategies. Initiatives that address the health needs of one gender should not occur at the expense of the other.

"Men and women should be given equal opportunity to realise their potential for a healthy life.

"The AMA congratulates Health Minister, Greg Hunt, for his decision to begin the process to establish a National Male Health Strategy for the period 2020 to 2030.

"We look forward to engaging with the Turnbull Government to develop initiatives to address the reasons why men are reluctant to engage with GPs, and the consequence of that reluctance, and to invest in innovative models of care than overcome these barriers.

"Compared to women, Australian men not only see their GP less often but, when they do see a doctor, it is for shorter consultations, and typically when a condition or illness is advanced.

"Men's Health Week is an opportune time for Australian men to do something positive for their physical or mental health – book in for a preventive health check with a trusted GP, get some exercise, have an extra alcohol-free day, or reach out to check on the wellbeing of a mate."

The AMA *Position Statement on Men's Health 2018* is at https://ama.com.au/position-statement/mens-health-2018

The Medical Journal of Australia • MJA
MEDIA RELEASE

ABORIGINAL VACCINATION RATES BOOSTED BY PROGRAM

EMBARGOED UNTIL 12:01am Monday, 25 June 2018

A TARGETED program to meet the needs of Indigenous Australians has made a significant improvement to the vaccination coverage rates and timeliness in New South Wales and "closed the gap" since its introduction in 2012, according to the authors of research published online today by the *Medical Journal of Australia*.

The Aboriginal Immunisation Healthcare Worker (AIHCW) program, funded by NSW Health to the tune of $1.3 million per year, placed up to 13 fulltime-equivalent AIHCW positions in public health units across NSW.

Using data from the Australian Immunisation Register (2008-2016), the researchers, led by Dr Alexandra Hendry from the National Centre for Immunisation Research and Surveillance, found that "the proportion of Indigenous and non-Indigenous children classified as fully vaccinated at 9, 15, and 51 months [of age] increased significantly in both NSW and the rest of Australia after the introduction of the AIHCW Program".

"The mean annual difference in full vaccination coverage between Indigenous and non-Indigenous children in NSW aged 9 months declined from 6.6 during 2008–2011 to 3.7 percentage points during 2012–2016; for those aged 15 months it declined from 4.6 to 2.2 percentage points; and for those aged 51 months it declined from 8.5 to 0.6 percentage points.

"In 2016, Indigenous and non-Indigenous coverage was not statistically different at any of the three milestones in NSW: at 9 months the difference was 1.6 percentage points; at 15 months, 0.4 percentage points; and at 51 months, -1.8 percentage points (i.e. the gap had completely closed and Indigenous coverage was higher than non-Indigenous coverage).

"For Indigenous children aged 9 months, coverage rose from 78.9% in 2008 to 89.5% in 2016, and for non-Indigenous children from 85.6% to 91.1%. For Indigenous children aged 15 months, coverage rose from 78.8% in 2008 to 88.4% and for non-Indigenous children from 82.5% to 88.7%," Hendry and colleagues wrote.

AIHCWs do not require formal qualifications, their role being to work with their communities and with individuals to promote the better use of existing vaccination services, rather than to directly provide vaccination services.

"Key activities of AIHCWs, most of whom are Indigenous Australians, include contacting parents of Indigenous children before scheduled vaccinations (pre-call notices), following up Indigenous children recorded on the Australian Immunisation Register as not being up to date with vaccinations, improving Indigenous identification, equipping providers with tools for monitoring timely vaccination of Indigenous children, and promoting vaccination in their local Indigenous communities," Hendry and colleagues wrote.

"[Our results suggest] that the commitment of significant resources to a dedicated program specifically targeted to the needs of Indigenous Australians, staffed by Indigenous workers who know their communities and are able to engage with them in a culturally appropriate way, may help overcome barriers to timely vaccination and have a marked impact on closing the vaccination coverage gap between Indigenous and non-Indigenous Australian children."

Please remember to credit The MJA.

The *Medical Journal of Australia* is a publication of the Australian Medical Association.

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AMA Adopts New Anti-Racism Policy

AMA Anti-Racism Statement 2018

The AMA Federal Council has formally adopted a new Anti-Racism Statement as AMA policy.

The Statement was produced by the AMA's Equity, Inclusion, and Diversity Committee,which was established in 2017 to support a culture that recognises the values of respect, equity, and inclusion.

AMA President, Dr Tony Bartone, said today that the Anti-Racism Statement demonstrates the AMA's commitment to opposing racism across the health care industry and in Australian society.

Dr Bartone said that the AMA acknowledges that an ongoing and shared commitment across organisations, governments, and individuals is required to eliminate racism in health care.

"We support a health care system that provides equity of access to quality care for all Australians," Dr Bartone said.

"The AMA is the peak advocacy body for all doctors working in Australia, and we represent a diverse range of individuals.

"The medical workforce is made stronger through the inclusion of people from diverse backgrounds who bring unique skills, perspectives, and networks to the health industry.

"Racism and discrimination have adverse, often very significant effects, and can contribute to the health burden of medical professionals and their patients.

"Racism can occur in both direct and indirect forms, including casual or everyday racism and implicit or unintentional racism, and can be experienced by a patient from their health care provider, by a health care provider from their patient, or between health care providers.

"Relationships in the workplace with superiors, colleagues, and patients must be free from bias, discrimination, and racism."

Dr Bartone said that International Medical Graduates (IMGs) from many different countries and cultures and faiths make a vital contribution to the delivery of health care in Australia, particularly in rural and regional locations.

In 2016, there were 12,495 reported overseas trained doctors in Australia. "It is vital that doctors and medical students are aware of, and sensitive to, cultural differences in their dealings with colleagues," Dr Bartone said.

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"Sensitivity and understanding of the diversity of patients must also be at the forefront of doctors' minds when delivering health care.

"There are aspects of the health care system that can be inadvertently exclusionary, and may deter some individuals from seeking health care."

The AMA also recognises that systemic and interpersonal racism has a detrimental effect on the growth and retention of the Aboriginal and Torres Strait Islander medical workforce.

Results from the Australian Indigenous Doctors' Association (AIDA) 2016 survey of their members revealed that more than 60 per cent of Aboriginal and/or Torres Strait Islander respondents had experienced racism and/or bullying every day, or at least once a week.

To minimise social and cultural barriers to health care and reduce inequalities, health care providers and organisations should have access to initiatives, training and resources - including interpreter services - that support them to deliver culturally safe health care, which is responsive to Australia's culturally and linguistically diverse communities.

The AMA believes that broad collaborative efforts within the health care sector can better utilise the benefits of the diverse cultures and languages within Australia to collectively work together towards the eradication of racism.

The AMA Anti-Racism Statement is at https://ama.com.au/equity-inclusion-and-diversity
4 June 2018

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"Guess You'll Be Thinking I've Gone Up In Smoke"

https://www.awm.gov.au/articles/blog/remembering-kathleen-neuss

Kathleen Neuss: "She was just a lovely fun-loving lady." When Australian Army nurse Kathleen Neuss sat down to write a letter home from Singapore on 6 February 1942 she couldn't have known it would be her last. "Guess you will be thinking I've gone up in smoke," she quipped. "There is plenty of it about."

Ten days later she was dead, one of 22 Australian nurses who were ordered into the sea at Radji Beach and shot by Japanese soldiers during the infamous Banka Island massacre. Her life was commemorated in a Last Post Ceremony at the Australian War Memorial, at which her family and friends laid wreaths in memory of those who were killed.

More than 60 years after her death, Michael Noyce found Kath's final letter among his parents' belongings. His father, William, was Kath's younger brother, and his mother Philippa was her best friend. "When my parents died, I found 20 odd letters in a little leather satchel," he said. "It was like Kath was there. It brought Kath alive."

Noyce never met his aunt, but he had grown up hearing her story. "As long as I can remember it was always Kath," he said. "She was never there in body, but she was always there in spirit, and her presence was always very strongly felt …

Australian War Memorial

"Reading and transcribing her letters … she became a real person. You knew her. You knew what her emotions were. You knew what she was thinking. You knew what she liked. You got to know her as a human being. You got to know her as if you were talking to her...

"She was just a lovely fun-loving lady. She was a tall, fun loving and gregarious woman with brown eyes and dark hair. She had a wicked sense of humour and was full of life, her letters home telling of young woman enjoying her experiences overseas …

"She nursed with my mother at Royal Prince Alfred in Sydney and they were best friends. Kath was a year or so older than my mother and … in October 1940 Kath's younger brother – my father – went to say goodbye to his sister before he embarked on the Queen Mary for the Middle East.


Kathleen Neuss courtesy by Michael Noyce.

"My aunt and my mother were living together in an apartment in Darlinghurst in Sydney, but he got his day or the hours mixed up and Kath was on duty nursing and mum was at the house. My parents met for 36 hours there and then he went away for two and a half years. He came back and they were married four and a half days later … [so] I wouldn't exist if my father hadn't mixed up the times to say goodbye to his older sister.

"She was very close with my father, even though they were five or six years apart … My father kept a diary leading up until the siege of Tobruk which he gave to me not long before he died. We didn't even know it existed, and the diary was given to him by Kath. On the back it's got, 'Finish this Willy and I'll give you another one for next year.' But she was killed in the meantime."

Neuss enlisted in the Australian Army Nursing Service in December 1940 and embarked for Singapore in February 1941 on the SS Queen Mary, the same ship her younger brother William had sailed on only a few months earlier.

She was working on the Malay Peninsula when the Japanese attacked the US naval base at Pearl Harbor in December 1941 and invaded Malaya. Once the fall of Singapore became inevitable, Neuss was one of 65 Australian nurses who were evacuated. Although they protested leaving their patients, the nurses left Singapore on 12 February aboard SS Vyner Brooke. Two days later, the desperately overcrowded ship was attacked and bombed by the Japanese, sinking in the Banka Straits within half an hour of Sumatra.

Continued Next Month