RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
November 2010

Pumicestone Passage

See Pumicestone Passage featuring in our Historical Article in this edition page 3 and our regular Pictorial Page 20 .

RDMA President's Message ... Dr Wayne Herdy

Redcliffe & District Local Medical Association (RDMA) progresses further into the 21st century as our Treasurer adds to our techno armamentarium with the launching and development of our own website (read the article inside). The website can be accessed on rdma.org.au.

It is a humble beginning. The page is still under construction. The main content so far is a page linking to our present and past Newsletters. However, from humble beginnings we will expand and refine to bring our LMA into the internet information age and proudly put ourselves out for the whole world to see.

But give us time. Rome was not built in a day, and the builders in this case are all volunteers. For those who are into such things, we are going to add a page outlining the history of RDMA. We would like to hear from all the members who have been around for a while, who can give us details of our history and add those little anecdotes that make the narrative come to life. Our email contact is RDMAnews@gmail.com

Again I invite YOU to contribute to YOUR Association, write articles of general or clinical interest for YOUR Newsletter, and now I am inviting you to write down a few memories of the history of YOUR Association for inclusion in the growing record of this wonderful organization. The development of this website marks another developmental milestone as the Association takes adult steps into the information era. We can be justly proud that we are among the leaders in LMA growth.

Wayne HERDY,

DATE CLAIMERS :

For all queries contact Tracey: (07) 3049 4429

Venue: The Ox, 330 Oxley Ave, Margate
Time: 7.00 pm for 7.30 pm

2011 Dates:

Wednesday	February 23
Tuesday	March 29
Wednesday	April 27
Tuesday	May 31
Wednesday	June 22
Tuesday	July 26

Annual General Meeting

Wednesday	August 31

Tuesday	September 13
Wednesday	October 26

Year End Networking Function

Friday	November 25

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JANUARY NEWSLETTER 2011

The 31st December 2010 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com or Fax: (07) 5429 8407
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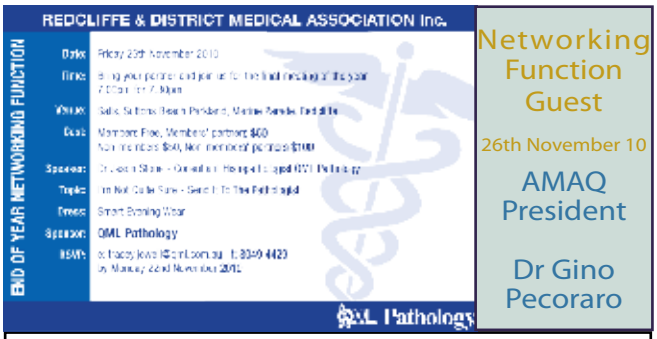
NOTICE - SPECIAL GUEST ATTENDING



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INSIDE THIS ISSUE:

Pumicestone Passage

PUMICESTONE PASSAGE is the inlet of the sea that separates Bribie Island from the mainland. Traversing 35km from Caloundra in the north to Deception Bay in the south, it is a passage so narrow that it could be mistaken for a river, and so shallow for most of its length that it offers no passage at all. Eighty per cent of the water is less than two metres deep.

Named in 1799 by Matthew Flinders, who remarked on the quantities of volcanic pumice rock floating in the vicinity, it long served to limit enjoyment of the sandy Bribie Island to boat owners.

The now ancient bridge looks decidedly tottery today but was the development that allowed a meteoric increase in the population of the island. Most early dwellings were mere shacks, weekenders, and it was not until quite recently that the quaint fishing-village character of the island made way for the present urban sprawl.

Older members of the Association might remember the barge that used to operate just north of the present bridge, and first allowed vehicular traffic to explore the primitive tracks that crossed to the surf fishing on the ocean front. Not-so-old members will remember that the bridge opened half a century ago as a toll bridge.

The passage is now a marine park, home to dugongs, turtles and dolphins.

Pumicestone Passage

AMA The Medical Journal of Australia
Established 1914 • Journal of the Australian Medical Association
eMJA

ONE-THIRD OF DOCTORS CONSIDER GIVING UP MEDICINE DUE TO MEDICOLEGAL CONCERNS

Medicolegal concerns are affecting how Australian doctors practise medicine, according to an article published in the Medical Journal of Australia.

Dr Louise Nash, coordinator of the postgraduate course in Psychiatry and Master of Psychiatry at the New South Wales Institute of Psychiatry, Sydney, and co-authors conducted a survey of Australian doctors to explore the perceived impact of medicolegal concerns on how they practise medicine, and to compare doctors who have experienced a medicolegal matter with those who have not.

Dr Nash said that medicolegal concerns can prompt changes to the practice of medicine that could be beneficial and detrimental to patient care.

The study identified a link between changes in doctors practice of medicine and medicolegal concerns. Forty-three per cent of doctors indicated that they referred patients to specialists more than usual, 55 per cent stated that they ordered tests more than usual, and 11 per cent stated that they prescribed more medications than usual due to these concerns.

Concerns for medicolegal issues led to 33 per cent of doctors considering giving up medicine, 32 per cent considering reducing their working hours, and 40 per cent considering early retirement. These proportions were all significantly higher for doctors who had previously experienced a medicolegal matter compared with those who had not.

Respondents also reported improved communication of risk to patients (66 per cent), increased disclosure of uncertainty (44 per cent), development of better systems for tracking results (48 per cent), better methods for identifying non-attendees (39 per cent), and better methods for auditing clinical practice (35 per cent).
Dr Nash said that targeted training in patient safety and medicolegal aspects of medical practice would help doctors to be better informed and to better understand how such issues influence their judgment and decision-making.

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

CHANGES TO CLASSIFIEDS

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

Classifieds will be published for a maximum of three placements.

Classifieds are not to be used as advertisements.

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

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION MEMBERSHIP

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

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

Meeting dates are in the date claimers on page 4
COST for non-members:
$30 for doctor, non-member

RDMA WEBSITE COMES TO LIFE

Dr Wayne Herdy, RDMA President

Go to your internet and search under rdma.org.au. You will see the fledgling RDMA website, modestly hallmarked "this site is still under construction".

True, there is not a lot of content yet, but the plan is to make this a much more interesting site.

What we propose putting on REDAMA's website includes pages with:

(a) the history of the LMA;
(b) links to related organizations (including members who have their own websites);
(c) details of our office bearers;
(d) a list of past presidents;
(e) the Rules of the Association;
(f) an application for membership;
(g) a list of members ;
(h) articles of interest in our region;
(i) a current political update;
(j) a feedback page or chat page.

We need the help of you, our members, to grow this into a more exciting and useful website:

(1) HISTORY. No single person knows the history of the organization, including a comprehensive list of past presidents – so we want you to talk to one of the executive members or write to the Newsletter editor or publisher. Any big changes that you remember, any little anecdotes that add flavour. Even if you think that "everybody knows that", don't assume that we do. We especially want names, not wanting to miss out any people who have made a real contribution. So any large or small offerings at this stage will help to make this history as an accurate a record as we can manage. GIVE US WHATEVER YOU REMEMBER ABOUT THE ASSOCIATION BEFORE THE MEMORY IS LOST FOREVER.

(2) PAST PRESIDENTS. With three or four decades behind us, nobody remembers who all the past presidents were, or when they served. It would be a shame to miss out on any individual who has donated his/her time to make your Association what it is. WRITE THE NAMES OF THE PAST PRESIDENTS YOU REMEMBER AND WHEN THEY SERVED.

(3) LIST OF MEMBERS. We are still mulling over this one. Not everybody will want the world to know about them. I can't see that what we plan publishing will create a security risk for anybody, but I can see that some individuals might be concerned to see personal details thrown out for the world to see. The information is intended for use of members to contact other members, but inevitably some commercial entrepreneur will mine the information to try to sell our members something. All we plan publishing is information already in the public domain – maybe just the name, maybe add practice address, phone number and specialty, definitely NOT email addresses or home addresses. If anybody has definite thoughts one way or the other, to publish or not to publish, contact one of the executive and make your thoughts known. We will be adding a line to our membership renewal forms to decline consent for inclusion of details on our website. If a majority of members decline consent, the list will be too non-representative and we will discontinue it. TELL US IF YOU THINK WE SHOULD OR SHOULD NOT INCLUDE A LIST OF MEMBERS.

(4) FEEDBACK PAGE OR CHAT PAGE. Before our Treasurer goes to the time and effort of creating this page, would anybody actually use it? LET US KNOW IF YOU WOULD ACTUALLY USE THIS PAGE TO FEED OPINIONS OR INFORMATION BACK TO THE EXECUTIVE AND THE MEMBERS.

WE NEED YOUR FEEDBACK AND STORIES. YOU HAVE CONTACT DETAILS OF THE MEMBERS OF THE EXECUTIVE, OF THE NEWSLETTER EDITOR AND THE NEWSLETTER PUBLISHER. TELL US WHAT YOU KNOW OR THINK.

AMA QUEENSLAND PRESIDENT

Dr Gino Pecoraro

Protecting the health of doctors in Queensland

The community has the right to private and confidential health treatment and so do health professionals.

A major topic which has caused much angst for members is the mandatory reporting legislation.

Strenuous lobbying to have this legislation amended has been a priority for AMA Queensland as it has major health consequences for doctors and their patients.

Recently AMA WA was successful in having their proposed legislation amended whereby mandatory reporting was excluded in a doctor-patient relationship where the patient is a fellow health practitioner.

In our past attempts to change the mandatory reporting policy which discourages doctors and other health practitioners from seeking medical treatment, we were told time and time again it could not be done at a state level. Western Australia has since proved otherwise.

Last month the Queensland Deputy Premier and Health Minister Paul Lucas and I had quite a positive meeting discussing the amendment of this legislation.

It was pleasing to see that the Health Minister understood our concerns and shared some of them. Lucas indicated he would raise our concerns at the next meeting of the Australian Health Ministers Council.

In the meantime, a submission is currently being drafted to the Health Minister highlighting that health professionals deserve to have the same rights to confidential health treatment as every other member of the community.

Patients must have confidence and trust in the health professionals treating them.

Without protecting the right of health professionals to seek their own private and confidential treatment, mandatory reporting may result in adverse consequences for patients as health professionals.

This issue is of the highest priority for AMA and we will not be backing down when it comes to something as serious as protecting the safety of health professionals and their patients.

If doctors are deferring their own health treatment out of fear of jeopardising their entire career because of this legislation then AMA Queensland must and will take the necessary action.

A coordinated effort between the AMA States and Federal AMA continues with an official letter being sent to Federal Health Minister Nicola Roxon urging her support of the legislation change.

Strong action to achieve our goals on this issue will continue and you can be assured AMA Queensland will not lessen the pressure on the Health Minister or Queensland Health.

On a final note I wish all of you a happy and safe Christmas and New Year and look forward to working with you in addressing the many challenges that face our health system in the coming year.

Dr Gino Pecoraro

AMA Queensland President

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

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DOCTORS SUPPORT COLLABORATIVE CARE, NOT FRAGMENTED CARE

The AMA today reaffirmed that it does not support nurse practitioners working independently of doctors.

AMA President, Dr Andrew Pesce, said today that the AMA supports meaningful collaborative care arrangements between doctors and nurses under new measures that came into effect this week, and welcomes Health Minister Roxon's public confirmation that the arrangements will not make nurse practitioners substitutes for doctors.

Dr Pesce said the Government and the health professions must be vigilant to ensure that the new arrangements provide the best possible care for patients and that some proposed models of care do not attempt to work against the spirit and the intent of the new legislation.

"Doctors support genuine collaborative care arrangements where doctors and nurses work together to provide complete ongoing care for their patients," Dr Pesce said.

"It is important that the family doctor remains involved in patient care through the collaborative arrangements.

"We note comments from the Health Minister yesterday where she acknowledged that there have been misinformed claims in the media this week about the effect of the new measures.

"There is no place for models of care that may seek to operate under the new system without genuine collaborative arrangements between doctors and nurses, or which may distance the patient from their family doctor.

"An AMA public survey earlier this year found that 88 per cent of Australians have a regular family doctor and that 83 per cent of Australians were satisfied with the medical care they received from their family doctor.

"The survey also found that 82 per cent of people agreed that the best outcome for patients is to have doctors and nurses working together, and 76 per cent agreed that nurses cannot replace family doctors because they lack the training to diagnose and treat the full range of illnesses.

"Proper medical diagnosis is at the heart of quality health care and must be at the heart of the new collaborative care arrangements.

"Collaborative care must be all about complete patient health care, not the fragmentation of health care.

"The AMA looks forward to working closely with the Government in monitoring and reviewing the new collaborative arrangements as they are rolled out to ensure that only genuine quality collaborative arrangements are in place to serve patients and communities."

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5 November 2010

CONTACT: John Flannery 02 6270 5477 / 0419 494 761

Asset Allocation And Your Investment Strategy

The essence of asset allocation is diversification. By spreading your investments across different types of securities you not only reduce the risk of your portfolio losing money; you also increase the chance that it will make money. Of course no matter what asset allocation you choose, there's no way to eliminate risk entirely. Investing always involves the risk of loss.

One of the key principles of diversification is the 'risk-return trade-off'. Understanding the risk/return trade-off for the various asset sectors is very important. That is, the greater the returns, the greater the risk you take; and vice versa. One of the most important decisions you will make is how much to allocate between the asset classes as your choice will fundamentally determine the long-term investment returns and fluctuations (volatility) of your portfolio.

Unfortunately, a dilemma every investor faces is that it is very difficult to predict future performances of each asset class. When one sector is underperforming the market, another sector could be outperforming – if you had all your money in just one asset class you could be missing out on potential returns from other sectors. Therefore, by spreading your exposure and investing in different assets you create a portfolio in which you are able to minimise to some degree the losses that may occur in one asset sector with gains in another.

Income And Growth Assets

Successful asset allocation means achieving your objectives with the least possible risk. To do this you need to understand the behaviour of asset classes and products. You can see from the following table how defensive assets such as cash and fixed interest pay relatively good income, but have no growth and therefore low risk. Shares on the other hand have high potential for capital growth and so the risk factor is also higher. What this tells you is not expect higher returns without higher risk, and do not expect safety without correspondingly low returns.

Asset Class	Income	Capital Growth	Tax Effectiveness	Risk
Defensive Assets				
Cash	Low/Medium	None	None	Low
Fixed Interest	High	None	None	Medium
Growth Assets				
Australian Shares	Medium	High	High	High
International Shares	Low	High	Low	High
Property	Low/Medium	Low	Medium	High

The Right Mix; The Right Portfolio

The right mix of income and growth assets will vary from person to person, depending on your individual needs and circumstances. In practice however, with many investors exposed to property through their own home, the asset allocation decision comes down to how much to invest in shares, and how much to invest in fixed interest and/or cash. As a general rule, your allocation to shares should be higher if you plan to stay invested in those shares for an extended period of time. The reason for this is that the longer your time horizon, the more likely it is shares will outperform fixed interest. That said, even if you plan to be invested for many years, you must still be comfortable with the higher risk level associated with a portfolio with a large allocation to shares. Investors with a shorter time horizon should focus on cash and fixed interest, as holding shares for short periods can be risky.

As you approach retirement you should consider increasing your portfolio allocation to cash and fixed interest. The reason for this is that you can no longer count on salary income to sustain you should the share market have a period of negative returns. This is a case where you must distinguish between the risk level you are comfortable with, and the risk level you can actually live with if things go bad.

Prepared by Terri Loy, Technical Services - RBS Morgans Ltd

MEDICAL MOTORING

with Doctor Clive Fraser

Motoring Article #76

Car Salesperson "Have I Got A Deal For You"

As Christmas is almost upon us it's a great time to reflect on what has happened in the past 12 months.

For starters, and as predicted, the federal election produced a hung parliament which means that we'll have another election sooner rather than later.

And 2010 saw the introduction of national registration which should be a boon for grey nomad doctors hitching up their caravans and heading off to do locums as they do a loop in their retirement.

One bonus from national registration saw me briefly acknowledged as a specialist in Public Health, a qualification I'd neither sought nor studied for.

Just as well that it was also my responsibility to point out the error which miraculously disappeared before I could make the call.

So what does the future and 2011 hold?

Well for myself I've been thinking of making a career change.

I wouldn't mind more study and a break from medicine so I thought I'd enrol in a TAFE course to become a Licensed Motor Dealer.

I've been doing some of the preliminary reading and I've really enjoyed unravelling all of the car salesman's secrets, some of which I'll share with you.

For starters I've discovered that car salesmen share much in common with medical graduates.

They're meant to display "enthusiasm, the right attitude and dedication" which just about sums up the last 30 years of my medical career.

But where we differ according to their text is that customers who make statements like, "I'm just looking, I'm not going to buy today, I want to think about it" are really seeking reassurance from the salesperson that he or she can and is willing to help.

Forgive me if I missed something but I grew up believing that 'no' meant 'no', but apparently not in the motoring world.

You see within the first few minutes of meeting a prospective customer the car salesmen is meant to have categorized the customer according to the "SPACED" algorithm.

This means that the buyer is seeking Safety, Performance, Appearance, Comfort, Economy or Durability.

In psychiatric terms we'd utilise the DSM IV classification system which would categorise the individuals as dependent, anti-social, narcissistic, borderline, obsessive-compulsive or paranoid.

Either way the salesman is encouraged to "memorise their presentation, practice it over and over in front of a mirror, and even record it and listen to it and improve on it". A lot like preparation for a viva I thought.

Once all of the psychology is underway it's time for the test-drive.

The text recommends that the salesperson drives first along a planned route.

That gives an opportunity for "the feature presentation" and essentially takes full control of the whole exercise.

Then it's time to hand over at a scenic turn-around spot which provides an opportunity "to view the vehicle in pleasant surroundings".

On the way back there's plenty of time for what they call

"the trial close" which is the first attempt to close the deal.

If you're anything like me you'll balk at that point and make a comment like "It's too expensive".

This honest offering won't faze the salesperson who'll retort with "Do you mean that the list price is too high or the repayments?"

"We can re-structure the financing over 25 years and that will make it more affordable (sic)!"

The vignette I liked the best in the text was about what the salesperson is instructed to say when the customer says "I need to talk to my wife".

"I understand, Doctor Fraser. You know, you previously said that your wife didn't have to be involved in the decision to buy a new car. Also, you wanted to surprise her with it. You like the car and know it's what you want and need, but your wife may not agree, and this will only lead to confusion. She'll be so excited when you take it home that she won't question your decision".

"Now, Doctor Fraser, if it's absolutely necessary for your wife to see the car before you buy, let's take it to your house or pick her up at work. Tell her you bought the car and that I'm along to show you how the equipment works".

I had to put the book down at that point and decided that seeking clarification from my spouse was not advisable.

Maybe I'm not cut out to be a car salesperson after all.

Car salesperson

For: A shiny tie and photos of the family on your desk.
Against: Most spouses expect total honesty.

This job would suit: Doctors who don't mind stretching the truth

Specifications:

$70 commission per car
$200 extra for in-house financing
Expected to sell 16 cars per month
Super-ego not necessary for this career

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com.

RDMA MEETING 27/10/10

Clockwise from mid centre: Philip Dupre, Vice President and Co-Chair of the Meeting Kimberley Bondeson, Bernard Chan and Eugene Lim, Bram Singh, Treasurer Peter Stephenson, Secretary Ken Fry and Najana Warasinghe, Guest Speaker Christian Hamilton-Craig, Meeting Convenor Tracey Jewell, Jonathon Orr, Patron Reg Neilsen, Lyn Ferguson and Jeff Karrasch, Jai Raj, Premila Balakrishman and Pravin Kasan, President and Chair of the Meeting Wayne Herdy, Mal Mohanlal.

Special Guest Attending:
AMAQ President Dr Gino Pecoraro

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

END OF YEAR NETWORKING FUNCTION

Date:	Friday 26th November 2010
Time:	Bring your partner and join us for the final meeting of the year 7.00pm for 7.30pm
Venue:	Sails, Suttons Beach Parkland, Marine Parade, Redcliffe
Cost:	Members Free, Members' partners $50 Non-members $50, Non-members' partners $100
Speaker:	Dr Jason Stone - Consultant Histopathologist QML Pathology
Topic:	I'm Not Quite Sure - Send It To The Pathologist
Dress:	Smart Evening Wear
Sponsor:	QML Pathology
RSVP:	e: tracey.jewell@qml.com.au t: 3049 4429 by Monday 22nd November 2010

QML Pathology.

Guest Speaker, Current Office Bearers, and Past Office Bearer 27/10/10

Clockwise from the mid centre: Patron Reg Neilsen, Treasurer Peter Stephenson, Secretary Ken Fry, Meeting Convenor Tracey Jewell, Guest Speaker Christian Hamilton-Craig: Topic Risk Assessment and New Technologies-Which Test for Which Patient, Vice President Kimberley Bondeson, President Wayne Herdy and attending members.

MORETON BAY GENERAL PRACTICE NETWORK OFFICE MANAGER

Ms Bronwyn Coe

Allied Health Professional Visitors from Hong Kong

Moreton Bay General Practice Network has been hosting a study tour for allied health professionals from Hong Kong Hospital Authority over the past week; part of a 2 week tour. This has included providing an overview of our Federal and State Health frameworks, accreditation in the Flinders University Chronic Condition Self-Management Model, and various clinical placements in primary health care facilities within our jurisdiction. This has been coupled with an opportunity to experience the great south east weather and notable tourist locations such as the Gold and Sunshine Coast, Brisbane City and Southbank precincts. Delegates were honoured to attend a formal dinner hosted by MBGPN and Novo Nordisk. Dr Chrys Michelides a GP who specialises in Diabetic patient management provided an excellent clinical presentation at the dinner on how to manage and live well with Diabetes.

The second week of the tour will include sharing as much information as we can in relation to primary health care practice. Delegates will depart Brisbane on 30 October 2010, hopefully having experienced a worthwhile study tour enhancing their respective clinical practice in primary health and research.

L-R: Leo Ho, So Chi-Tao, Paul Sutton, Michelle O'Toole, Catherine Wong, Peggy Wong, Barbara O'Toole,Eddie Leung, Harriet Lo

AMAQ & FEDERAL COUNCILLOR REPORT

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

As students of history learn, you can open any history book at any page and there will be two messages. The first is "it was a time of great change". The second is "there was a rising of the middle classes".

That is what we are seeing today. It is indeed a time of great change in medical politics. It is also a time when the professional classes of Australia, or at least the health professionals, are swelling the ranks of the middle classes.

A TIME OF CHANGE.

The time of great change commenced with the Rudd government's health reforms of 2009. The same changes, with only minor editing, are being progressed by the Gillard regime. Thankfully in the minority government environment, the changes are proceeding slowly and carefully, not to upset those who will vote in the next election. In the intense lobbying on all sides, all parties are actively listening.

It is a truism of politics that even the least intellectual of politicians recognizes the conflict in those last few words. Practically all politicians recognize what reforms will be best for the country as a whole, both in the short term and the long term. They all know what changes are most likely to get them returned at the next election. With few exceptions, the two never coincide. With few exceptions, the only politicians who follow the betterment of the country over the betterment of their chances of re-election are those who are not planning to be re-elected.

The fundamentals of the change are based around the restructure of health service delivery. The rationale is economic reform. The system is costly and wasteful. Doctors keep creating high-end technology which accounts for most of the expansion in the health budget. Politicians want the high-cost stuff to be available for their electorates. The system that pays for the health budget wants the system that delivers the health product to stop the waste. Simple as that.

The Rudd/Gillard experiment is aimed at changing the structure to reduce waste. But there is a strong underlying socialist agenda, to simultaneously improve access. Access means not only making a more level playing field so the disadvantaged get equity, ie the same health services as are available to the wealthy. It also means getting health services to those who presently just don't get anything at all. That is a noble ambition, but there are some who believe that the Labour party hasn't got it properly worked out yet. That is why the AMA is lobbying so strongly now, to make sure that the policy-makers really have the chance to properly understand the deck chairs that they are shuffling around on the decks of a ship that we hope will not follow the Titanic.

In practical terms, what we are seeing today is a lot of groups with special interests jockeying for position to be part of the finish to this race. The two most influential groups are the State health departments and the Division movement. Health departments are rushing to decide how many health districts they will finally have and how many local health networks they will fit into them. Divisions are rushing to do exactly the same to become preferred providers for the unknown number of Medicare Locals (formerly Primary Health Care Organizations) that are expected to more or less align with the LHN's. Both groups are fixated on numbers of LHN's and Medicare Locals that the Roxon ministry declared last year, before the election but based on the report from the National Health and Hospital Reform Commission. The numbers are becoming increasingly rubbery, partly because of the reality of Australia's geography and partly because of the reality of minority politics and the need to keep voters calm as we prepare for the next election. As well as the final numbers of LHN's and Medicare Locals, the health departments and Divisions are struggling to shift the boundaries to get them right.

THE RISE OF THE MIDDLE CLASS.

Doctors have long regarded ourselves, and let's be honest about it, as an elite society. This is not the place to discuss whether that status, which society at large willingly acknowledged, was deserved. Whether we are prepared to admit it or not, our elitism is being knocked down as tall poppies by the supposedly egalitarian socialist regime that rules in Canberra. Having had only limited success at dragging the medical profession down to the status of a craft guild or trade union, the trend is now to promote lower-level health practitioners up to the status previously enjoyed exclusively by doctors. Welcome to the middle class, colleagues.

Now that is not all bad news. Medical practice in 2010 is being dragged from the cottage industry that it was not long before I graduated. The ever-increasing complexity of medical management has turned the job from a solo act to a team collective. This is a very expensive exercise, but it is capable of producing better outcomes (recognizing that we are high on the curve of diminishing marginal returns). Team care is the necessary evolutionary step that is catching up with a sometimes-unwilling medical profession.

The other members of the team are skilled, well-trained and professional. We have to ensure that, as long as we insist that a doctor is always going to be the captain of the

Continued from Previous Page

team, we are more skilled and better-trained and more professional than those around us. This is not elitism. It is a necessary fact – that somebody has to be better than

all the others to lead in making the toughest of decisions when the heat is on.

COLLABORATIVE ARRANGEMENTS WITH NURSE PRACTITIONERS.

The Rudd Labour government introduced legislation which allowed Nurse Practitioners and midwives to have direct access to the MBS and PBS. That means that they can get Medicare benefits for consultations, and have prescribing rights limited only by any restrictions imposed by the States. Following its policy of opposition to INDEPENDENT Nurse Practitioners, the AMA had the draft legislation amended so that the Nurse Practitioners and midwives must be in a collaborative agreement with a doctor.

The legislation came into effect on 1st November.

The AMA is not opposed to Nurse Practitioners. In these days of increasing attention to chronic and complex care, and the increasing use of higher-end medical technology, doctors are increasingly working in team care arrangements. What the AMA is insistent on is that the head of the team must always be a doctor, and that the team members (including Nurse Practitioners) must be part of the team, working in a delegated role. Nurses must never become substitutes for doctor.

Already, there have appeared nurse-led clinics, typically walk-in clinics, with not a single GP in sight. This has raised debate about what constitutes a genuine collaborative agreement sufficient to satisfy the legislation. The AMA has asked the Minister to clarify what will have to be done between the doctor and the Nurse Practitioner to create a genuine collaboration.

What GP's might now start seeing is patients presenting requesting retrospective "referrals" just as we experienced with EPC referrals to psychologists and dentists.

Doctors are justly worried about what their liability is if they have been identified as a patient's usual treating doctor, and if they start receiving pathology or other reports created from a Nurse Practitioner consultation to which they have not been a party. Initial advice is that the doctor who receives the report does acquire some liability for ensuring that the report is appropriately followed up. The AMA is asking the MDO's for definitive advice on the liability of the doctor who receives a third-party report, but readers should contact their own MDO's in that situation.

For guidance on what to do if you want to create a collaborative arrangement with a midwife or Nurse Practitioner, or what to do if one approaches you wanting you to endorse their role in a collaboration, there is a comprehensive guide on the AMA website.

CONCLUSION AND DISCLAIMER.

This column has not been what was originally intended, ie a report on what your AMA is doing for you right now. That is because the reform process is proceeding so cautiously. So I have exercised my prerogative to use this month's column to philosophise on where we are going from where we have been. As always, the opinions expressed herein are not necessarily AMA policy (although I believe they reflect mainstream AMA thinking), and are those of your correspondent.

STOP PRESS: SINCE THIS ARTICLE WAS WRITTEN, THE AMA CLAIMS A HUGE WIN IN THE DIABETES PLAN. THE GOVERNMENT HAS BACKED DOWN ON THE PROPOSAL TO PAY A FIXED AMOUNT FOR CARE OF DIABETICS, AND FEE-FOR-SERVICE HAS BEEN RESCUED. THE PLAN IS BEING "REVIEWED" SO WATCH THIS SPACE. BUT IT LOOKS AS IF THE AMA HAS SUCCESSFULLY WARDED OFF THIS BLATANT FUNDHOLDING EXPERIEMENT.

Wayne HERDY

AMAQ CONFERENCE - BOSTON 2010

Dr Kimberley Bondeson,

BOSTON, AMAQ, 2010.

This was my 10th AMAQ Conference in a row – Why do I keep going? Because they are fantastic!

Each year they are different, in a different country and on a different topic.

View of the Boston Harbour from the Conference Hotel in Boston

This year in Boston, the theme was "Caring for an Ageing Population", a topic relevant and facing all of us. There were varied speakers, ranging from our very own president, Dr Wayne Herdy, who shared with us his experiences in Aged Care and Respite Care in the remote Australian Outback, to Dr Zaldy, Assistant Professor at Harvard Medical School, who talked to us about Dementia and Alzheimer's, and shared some of his research with us.

The sessions were varied, and mixed in amongst the sessions were speakers from Boston who described the current Health Reform that is currently being promoted in America. It was interesting to see the comparisons with Australia, and hopefully, as their situation unfolds, we can avoid some of the same pitfalls.

Lunch in a town called "Sandwich", in Cape Cod, near Martha's Vineyard

I heard that America spends more on health per head than any other country in the world (20% of it GNP).

Starbucks spends more money on health insurance for its staff than it does on coffee beans. One thing we did notice was that there was a Starbucks on every street corner, not only in Boston, but in Montreal, Niagara Falls, Buffalo, and New York, through which we traveled by train on our way to Boston.

Boston itself was a delight – it initially reminded me of a small English Village. Its history goes back to when the pilgrims landed in Cape Cod (yes, we all went there and had a look), except that the seafood, particularly the lobsters were enormous and delicious. I was told by a local that the lobsters were so plentiful in the bay that they were initially used as animal feed.

The farewell dinner was held at the Harvard Club – the same dining hall that the Harry Potter's films were shot in. We kept expecting to see an owl flying overhead.

On the way over, we stopped at Niagara Falls, and on the way back, we caught a train from Boston to New York. The entire trip was memorable, and I look forward to Prague next year (yes, I am going again).

This man was just walking along in a Park in Boston. His rifle was real.

An amazing hotel room view of "Niagara Falls". At night time the Niagara Falls were all lit up.

Interesting Tidbits

NATTY MOMENTS:

NINE WORDS WOMEN USE

(1) Fine:
This is the word women use to end an argument when they are right and you need to shut up.

(2) Five Minutes:
If she is getting dressed, this means a half an hour. Five minutes is only five minutes if you have just been given five more minutes to watch the game before helping around the house.

(3) Nothing :
This is the calm before the storm. This means something, and you should be on your toes. Arguments that begin with nothing usually end in fine.

(4) Go Ahead:
This is a dare, not permission... Don't Do It!

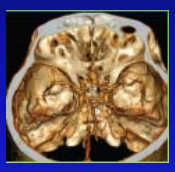
(5) Loud Sigh:
This is actually a word, but is a non-verbal statement often misunderstood by men. A loud sigh means she thinks you are an idiot and wonders why she is wasting her time standing here and arguing with you about nothing. **(Refer back to # 3 for the meaning of nothing.)**

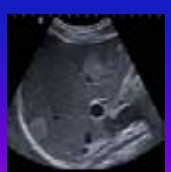
(6) That's Okay:
This is one of the most dangerous statements a woman can make to a man. That's okay means she wants to think long and hard before deciding how and when you will pay for your mistake..

(7) Thanks :
A woman is thanking you, do not question, or faint. Just say you're welcome. **(Unless she says 'Thanks a lot' - that is PURE sarcasm and she is not thanking you at all. DO NOT say 'you're welcome' that will bring on a 'whatever').**

(8) Whatever:
Is a woman's way of saying F--- off!

(9) Don't worry about it, I'll do it:
Another dangerous statement, meaning this is something that a woman has told a man to do several times, but is now doing herself. This will later result in a man asking 'What's wrong?' **For the woman's response refer to # 3.**





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MINISTER MUST URGENTLY CLARIFY REGULATIONS FOR COLLABORATIVE CARE

AMA President, Dr Andrew Pesce, said today that the Health Minister, Nicola Roxon, must urgently clarify the intent and coverage of the new regulations for collaborative care arrangements between doctors and nurse practitioners.

Dr Pesce said that claims in the media by some groups, especially [named] clinics, that their models of care are eligible for access to Medicare and the PBS are throwing the new arrangements into disarray and confusion.

[Named] Clinics are mostly located in pharmacies and are staffed by independent nurse practitioners, not doctors.

The [named] clinics website is today carrying this message - ***Medicare rebates available on [named] clinic services from 1st November 2010.***

"The AMA supports collaborative arrangements where a doctor is in a position to provide advice and medical support when required for patients being seen by nurse practitioners," Dr Pesce said.

"We also believe this arrangement must be agreed and formalised before a patient is seen by a nurse practitioner.

"This is in keeping with the spirit and intent of the legislation. It is the best model of care for patients.

"We do not support contrived arrangements that may involve correspondence with a 'remote' or 'distant' doctor who signs off on a written protocol but who cannot provide advice and direct medical support when required.

"While we recognise that special arrangements with doctors will be necessary for some nurse practitioners working in remote locations, these must be exceptions, not the norm.

"We call on the Minister to urgently clarify the types of collaborative care arrangements that the Government intended would attract Medicare rebates.

"This is essential to provide certainty and confidence to the doctors and nurses who are committed to genuine collaborative care arrangements that will provide comprehensive quality care for their patients," Dr Pesce said.

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11 November 2010

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MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

REDCLIFFE AND DISTRICT LOCAL MEDICAL ASSOCIATION INC.

The objects for which the Association is established are:

(1) THE PROMOTION OF THE MEDICAL EDUCATION OF THE MEMBERS, AND OF THE LOCAL COMMUNITY.
(2) PROMOTION OF THE MEDICO-POLITICAL INTERESTS OF THE MEMBERS, PATIENTS, AND THE LOCAL COMMUNITY.
(3) LIAISON WITH OTHER MEDICAL REPRESENTATIVE BODIES.
(4) THE PROMOTION OF QUALITY MEDICAL SERVICES.
(5) PROMOTION OF AN ENVIRONMENT TO FACILITATE AND ENCOURAGE SOCIAL INTERACTION BETWEEN ASSOCIATION MEMBERS.

We are here to

(1) TEACH AND LEARN
(2) BE INFORMED ON MEDICAL POLITICAL ISSUES AT ALL LEVELS
(3) LOBBY ON LOCAL POLITICAL ISSUES
(4) WORK WITH OTHER DOCTORS' GROUPS
(5) WORK FOR THE BENEFIT OF OUR PATIENTS
(6) NETWORK AND HAVE A GOOD TIME TOGETHER.

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YOUR MEMBERSHIP GETS YOU

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NOTE THAT AMA MEMBERSHIP DOES NOT GRANT YOU RDMA MEMBERSHIP.

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REDCLIFFE AND DISTRICT LOCAL MEDICAL ASSOCIATION Inc

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Signed:	
Doctor:	
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Email Address:	
Practice Address	**Postcode**
Phone	**Fax**
Please tick the appropriate box: "I do ☐ / do not ☐ give consent for my name and practice address to be included in the Association's website."	

Membership fee enclosed, or

PREFERABLY Paid by: Internet Banking (Remember to place your name on the deposit i.e: Dr. F. Bloggs RDMA) Account: BSB 064 122 Account: No: 0090 2422 Redcliffe & District Local Medical Association/ Date and Bank Paid

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