RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter

NOVEMBER 2011

North Lakes

See Northlakes and surrounds featuring in our Historical Pictorial in this edition page 3 and our regular Where We Live And Work segment Page 20

RDMA President's Message ... Dr Wayne Herdy

PRESIDENT'S REPORT

There are two current developments in RDMA's catchment area arising from the Labor health reforms.

The first surrounds the GP SuperClinic which has yet to see the light of day. The Redcliffe GPSC has fallen into a funding controversy. Although one of the first GPSC's to be announced, Redcliffe has yet to open its doors and does not have a GP in sight. The initial budget was insufficient to get the building completed and it has needed two Federal government bailouts, the second to prevent legal action from the builder. The extra cash was available from the GPSC budget after the Darwin GPSC and the Sorrell (Tasmania) GPSC were both abandoned as unsustainable and having lost the interest of potential tenderers.

The second development concerns the Medicare Local. We accept the AMA viewpoint that, apart from the basic contention that the Medicare Local concept is both structurally flawed and insulting to GP's, the ML governance is unacceptable as long as it has few or no GP's on the board. The Sunshine Coast ML has been announced. Unsurprisingly, the contract will go to the Sunshine Coast Division of GP. Unexpectedly and disappointingly, the Sunshine Coast ML will be among the final tranche, not to open until July next year.

Until now, the GPSC's and the ML's have been only superficially related as the two major components of the Labor health reform package. Recently, they have come together in an unexpected turn of events. A major thrust of both the GPSC ideology and the ML ideology has been to fill the gap in provision of after-hours services. A new development in our region this year has been the closure of two of the well-established after-hours clinics, at Kallangur and now at Caboolture.

We will have to watch closely to ensure that the proposed solution to our local after-hours GP service shortfall does not produce a total demise of after-hours GP services outside the greater Brisbane area.

Wayne HERDY
RDMA PRESIDENT

DATE CLAIMERS:

For all queries contact Margaret MacPherson Meeting Convener: Phone: (07) 3049 4429

Venue: Sails, Suttons Beach Parkland, Marine Parade, Redcliffe

Time: 7.00 pm for 7.30 pm

2011 Dates:

NEXT MEETING

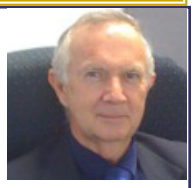
Year End Networking Function

Friday November 25

Special Guests:

Dr Steven Hambleton (AMA Federal President)
Dr Richard Kidd (AMAQ Queensland President)

CONTACTS:



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DECEMBER NEWSLETTER 2011

The 17th DECEMBER 2011 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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INSIDE THIS ISSUE:

North Lakes


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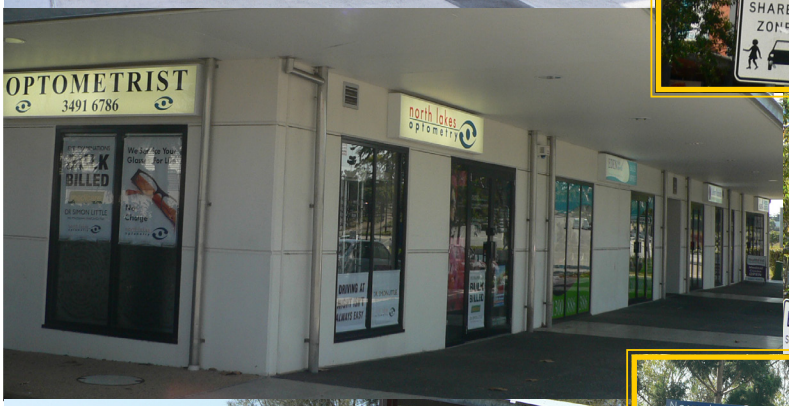
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NORTH LAKES
POLICE STATION


ARCARE on
Endeavour
Residential Aged Care

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT

Dr Richard Kidd

State Election Pending

As we all know a state election is pending. To ensure health remains front and centre of the debate, AMA Queensland launched a pre-election campaign, Time for Answers on 20 November.

To start the campaign AMA Queensland wrote to all major newspaper editors, radio journalists and television news editors and provided them with a series of questions for all candidates.

Following feedback from members in the Brisbane North Region, the following questions were sent to local media in your area:

1. Public hospitals in Queensland are chronically underfunded and the system is at breaking point. What will you and your party do to relieve pressure on the health system and ensure patients are properly cared for?

2. Brisbane Metro North needs 91 more beds today just to meet the national average of 2.6 beds per 1000 population. What will you and your party do to ensure that the number of Queensland Public Hospital beds in Metro North meets at the very least, the national average?

3. How will you and your party assist to recruit and retain the vital services of VMOs in hospitals, especially in regional and rural Queensland?

4. Long waiting times in Queensland public hospitals due to access block means very sick people in the Emergency Department may not be able to access an inpatient hospital bed. What will you and your party do to ensure patients receive treatment in a timely manner?

5. Many patients in Queensland are having their referrals for elective surgery rejected. What will you and your party do to ensure patients are treated in a timely manner?

6. Do you believe your party should commit to a goal of offering all Queensland medical students an internship after they have graduated from medical school as a way of helping to alleviate the doctor shortage?

7. Smoking has huge health and economic costs. What will you and your party do to resource smoking cessation services in your region?

8. Patients and their families cannot afford to park at some of Queensland's major public hospitals. What will you and your party do to address these concerns?

9. Acute Primary Care Clinics offering bulk billing services are currently being rolled out across the state by Queensland Health. There is concern within the medical community that these clinics may threaten the viability of existing general practices. Would you and your party commit to a moratorium on the roll out of these clinics?

10. In 2008/2009 111 patients died of suspected suicide after attending a Queensland Health Emergency Department. A shortfall in mental health beds, staffing and resources in Queensland's public hospitals is thought to be a major attributing factor. How will you and your party address this problem?

AMA Queensland intends to put all responses on our website so you and your patients can see what local candidates are saying.

As the election looms closer, it is up to us, the main independent voice for doctors, to ensure health is high on the political agenda.

The time for answers is now. It is the time for AMA Queensland to pull together and be the voice for medical professionals and our patients.

Dr Richard Kidd

AMA Queensland President

Redcliffe Hospital
News for GPs

October, 2011

Expanding children's specialist outpatient clinics

The Queensland Government is expanding children's health services across the Greater Brisbane metropolitan area, including Redcliffe Hospital, to better serve the health care needs of children, closer to their homes.

State and Commonwealth Governments have committed $2.8 million of capital funding to Redcliffe Hospital to enhance its existing services for children. By 2012 this will include six short-stay beds in the paediatric ward, four additional outpatient rooms to run clinics specifically for children and refurbishment of the emergency department waiting area to ensure a family-friendly environment.

In addition to the enhanced children's services at **Redcliffe**, the Government is also providing new and enhanced services for children at **Caboolture**, **Ipswich**, **Redland**, **Logan**, and **The Prince Charles hospitals**.

Choices – Private or Public

Under the latest National Health Care agreement, all patients are given the choice to be treated as a public or private (bulk-billed) patient and Queensland Public Hospitals can bulk-bill Medicare for some outpatient services.

Patients can choose to be treated as either a public or private patient if the GP provides a 'named referral' to an approved hospital staff specialist with Right of Private Practice.

There is no charge to patients who choose to be treated as a bulk-billed patient if they are Medicare Eligible.

Bulk-billed clinics are staffed by specialists and in many instances Registrars are also present. In most cases patients are assigned to the specialist of their choice however occasionally patients may be assigned to another specialist from the same specialty, for example if a specialist is on leave or there is a shorter waitlist.

Bulk-billed paediatric outpatient clinics

Redcliffe Hospital offers bulk-billed services for existing paediatric outpatient clinics. This means parents and carers can choose for their child to be treated as a private or public patient by a hospital paediatrician.

If seen as private patient, children will have access to paediatricians with Right of Private Practice, and the consultation and investigations performed will be bulk-billed.

Redcliffe Hospital has five paediatricians with Right of Private Practice.

How to refer to a bulk-billed clinic

The process of referral is the same as for any private specialist referral. Simply address the referral to the private clinic including a named specialist. If the child has seen a specialist at the hospital previously ensure this specialist's details are included to avoid the child seeing another paediatrician.

E-Referrals

Redcliffe Hospital is now able to receive E-Referrals. Auto-populating fields and drop-down menus make creating named referrals easy and convenient.

E-Referrals are transmitted directly to the hospital reducing paper usage and are saved directly into practice and hospital information systems.

Referrals are valid for 12 months unless a shorter period is specified by the referring doctor

Future enhancements will provide automated referral confirmation.

Summary of Redcliffe Hospital paediatricians and contact details overleaf.

Continued Page 16

Queensland Government

Sponsor Moreton Eye Group

Meeting held on 26th October 2011

Sponsor:
Frank Cummingham

Frank Cunningham, Naill Cunningham and Pravin Kasan

Frank & Naill Cunningham

Presenter:

Dr Mark Donaldson.

Topic:

Flashes and Floaters/ Tears and Detachments

Attending Members:
Graham Balin, Peta and Chris McLaran

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

END OF YEAR NETWORKING FUNCTION

Date:	Friday 25th November 2011
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 Steven Hambleton (AMA Federal President) and Dr Richard Kidd (AMAQ Queensland President)
Topic:	Wrapping up the year with an AMA bow
Dress:	Smart Evening Wear
Sponsor:	**QML Pathology**
RSVP:	e: Margaret.MacPherson@qml.com.au t: 3049 4429 by Monday 21st November 2011

QML Pathology.

New Member:
William Braun,

Attending Members:
Carol and Larry Gahan,

Attending Members:
Ray Collins & Geoff Talbot

Medical Students: Left to Right:

Eugine Ng, Michelle Lee, An Yoon Kyo and Vinesh Appaduare

The Redcliffe & District Local Medical Association RDMA Meeting held on the 26/10/11 was presided over by Dr Wayne Herdy, RDMA's President.

The Meeting Sponsor was Moreton Eye Group whose representative Frank and Niall Cunningham introduced the night's presenter Dr Mark Donaldson.

The topic of the night was . Flashes and Floaters / Tears and Detachments.

SNAPSHOT FROM THE PAST - Routine Testing Support

REDAMA Newsletter from November 1989 Issue 8, page 4

Redcliffe support for routine testing for AIDS and Hepatitis B

Dr Bob Brown

The Redcliffe and Districts Local Medical Association has thrown its support behind a growing campaign to allow for the routine testing of hospital patients for AIDS and Hepatitis B.

The campaign, which had been activated by the Gold Coast AMA, now involves the State branch with talks planned in the next few weeks to formulate a decisive policy.

The Redcliffe association executive, at its meeting this month, decided to support the call for legislation changes in the interests of protecting members of the medical profession.

Vice president, Dr Bob Brown says every patient going to theatre at Prince Charles Hospital is already tested for AIDS.

"The onus should not be on doctors to look for high risk aspects in patients.

"And the legislation should not stop at patients going to surgery.

"What about general practitioners treating a patient brought in bleeding?" he said.

The executive said there should be changes to allow private pathologists to test samples instead of requiring all testing to be done by the State Government.

"Under the present system, it can take up to a week to get a reply on a sample when it should be only 24 to 48 hours," Dr Brown said.

President, Dr Kerry Garske, said the risk of contracting AIDS from patients was not restricted to surgeons.

"Anaethetists are gravely concerned at the risk they face and dentists are in an extremely high risk group," he said.

"Why should the government try to protect the high risk groups yet force the medical profession to carry out their task with the threat of contracting a fatal disease hanging over their heads?"

At the October meeting of the Gold Coast branch, three candidates for the coming State Election were asked to outline their party's policy on legislation enabling routine testing for AIDS.

A media release issued after the meeting accused the three parties of "ducking for cover on the issue" and called for changes to be made as soon as possible.

State Health Minister, Ivan Gibbs, entered the debate with his own media release which was interpreted by some sections of the media to indicate that the Gold Coast and State branches differed on the issue.

That was later denied by State President, Dr John Waller who has offered to have talks with the Gold Coast executive to determine a firm policy.

AMAQ & FEDERAL COUNCILLOR REPORT

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

AMA PUBLIC HOSPITAL REPORT, HEALTH OF THE NATION & PROFESSIONAL SERVICES REVIEW

Two public documents have attracted considerable media attention over the past month – the AMA's Public Hospital report Card, and the Newspoll survey on public opinion on health matters.

AMA PUBLIC HOSPITAL REPORT CARD.
The AMA Public Hospital Report Card 2011 has very little joy for any government.

Hospital bed numbers per capita continue to fall. In 2008 the then Prime Minister, Kevin Rudd, promised an additional $4.8 billion, to create 3750 new beds and growing to 7800 additional beds by 2012-13. By June 2010, we counted only 433 new beds Australia wide.

Median waiting times for elective surgery have continued to show a slight decline. Only 78% of Queensland's category 2 elective surgery patients were seen within the clinically indicated time. In Queensland, the Surgery Connect programme has diverted long-wait public patients into the private sector, and now accounts for about 4% of elective surgery patients.

Hidden waiting lists are well known to Queensland doctors, and are highlighted in the report card. Queensland Health continues to deny that there is a waiting list to get on the waiting list.

In emergency departments – category 1 and 2 performance times are quite good, but only in WA are category 3 waiting times anywhere near target. The report card cites expert opinion that there is a 20-30% excess mortality attributable to exit block. In Queensland, only 59% of category 3 patients are seen within the recommended time. Media reports are commonplace of ambulances being put on bypass, or capacity alert, or ramping (choose your own term, the process and outcome are the same).

Bed occupancy remains above the AMA recommended level of 85%. Above that figure, there is no capacity to accommodate surges and epidemics and mass emergencies. Caloundra and Cairns Base Hospitals operated at over 100% capacity!

The AMA was gratified that the Public Hospital Report card attracted more media and public attention than any other single AMA event this year.

HEALTH OF THE NATION.
The Weekend Australian of 5-6 November featured a liftout entitled "Health of the Nation", including an analysis of a recent Newspoll survey on health. One journalist wrote that "the era of universal healthcare is effectively over". The crisis of medical manpower looms high in the poll, and the bottom line is that Australia's supposedly classless society has a two-tiered system. Those who can/will pay can get first-class treatment, those who cant/wont pay are relegated to an inferior service. The author wrote "it is a disgrace that a significant proportion of the population are not able to access healthcare because of cost barriers".

A few highlights:

- only about half of responders are happy to register with just one GP or GP clinic
- 77% believe that waiting times for GP's is very reasonable or quite reasonable
- somewhat worrying for continuity and the highest quality of care, 72% were prepared to attend a clinic staffed only by nurses [there is a case here for the AMA to run a public awareness campaign to explain why we believe that nurses alone are not enough]
- only 47% were "very confident" that they would receive high quality and safe medical care in the event of a serious illness, and a further 42% were "somewhat confident"
- despite what we perceive to be a plethora of corporate practices, only 14% attended a GP on a walk-in basis and a whopping 85% made an appointment
- only 39% were "very confident" that they would be able to afford the care they need, and another 38% were "somewhat confident
- a total of 45% had deferred or avoided medical treatment to save money.

Now what the article misses is a distinction between GP and specialist, elective and emergency. Because GP's see many disadvantaged patients, our bulk-billing rate remains very high, typically around 80%. The bulk-billing rate for specialists is much lower. The existence of cost barriers does not preclude any patient from accessing urgent and life-saving treatment.

Although it did not attract the wide media attention enjoyed by my first two topics, review of the PSR has attracted the attention of the medical media.

PROFESSIONAL SERVICES REVIEW.
The PSR has been the subject of a new Memorandum of Understanding, has had a new head appointed, and is still the subject of a Senate enquiry. All this amounts to an AMA win.

Despite the trend to include lawyers in the adjudication process, the profession is still entrusted to judge itself.

Some cases have been dropped entirely, some are still being judged. The outcomes do not reflect the merits of each case but are based on the finding that the process was faulty.

The process will now be more transparent and accountable. The Person Under Review (PUR) will now be given full information about the case – a fundamental of quasi-criminal proceedings in any other jurisdiction. The PUR will be able to object to inclusion of specific members of a tribunal, and in the event of dispute the PSR will defer to the views of the College to determine whether a tribunal member is reasonably considered to be a true peer of the PUR.

As always, any opinions expressed herein remain those of your correspondent,

Wayne Herdy

HISTORICAL ARTICLE - Negligence Claims Are On Increase

REDAMA Newsletter from November 1989 Issue 8 Page 7

Negligence claims are on increase

The subject of doctors needing to closely study their insurance coverage for negligence claims has become a matter for growing concern.

This special report on a recent Sydney Conference on Medical negligence, outlines the latest information.

There have been further developments in the area of medical negligence, these basically being:

1: Large increases in claims, e.g. 35% increase in claims in NSW in 1988.

2: Extension of claims to involve other parties such as hospitals, employers etc.

3: Detailed gathering of evidence and use of expert opinion.

1 - Large Increases in Claims

Due to the rising expectations in healthcare of patients along with the reduced esteem offered to doctors, it is believed these are two significant factors involved in this increase in litigation.

It is disturbing to note that this increase in medical negligence claims is increasing despite clear evidence of major steps forward in the standard of healthcare and technology.

Barristers at the conference stated that many patients were instituting claims against medical practitioners because they were angry or required information.

The situation where doctors are not open to free communication with a patient when a complication occurs, can lead to significant friction and anger and a subsequent claim.

Legal professionals who specialise in the area of medical negligence now have a panel of experts at their disposal and they usually obtain independent expert opinion early in the proceedings to ascertain the viability of the claim.

This situation leads to advice on many occasions that the claim is frivolous and the doctor may not even be informed that action was contemplated.

2 - Extension of Claims

Hospitals are now becoming frequent co-defendants in the area of negligence with hospitals being sued for vicarious negligence with respect to their employees and their duty of care.

Significant debate occurred at the conference regarding the link between visiting medical practitioners and the public and private hospitals which, at the moment, is an area of predicted future legal activity.

In certain instances, third parties such as employers, have instituted cross claims against doctors regarding the treatment of their employees. This is a new area of concern.

3 - Gathering of Evidence

All doctors should be advised that as well as the basic medical record in a hospital and their own clinical notes, some barristers are advising the subpoena of many other documents including personal correspondence between doctors, minutes of hospital meetings, quality assurance information etc.

We would be strongly advised to be extremely careful in the terminology used in all correspondence.

In cases involving informed consent, if the doctor does not have in his own notes details regarding statements given to the patient about the operation, then he would be at extreme risk if these notes were subpoenaed regarding a claim in this area.

There was significant discussion at the conference between medical practitioners and lawyers involving the pressure of work, time allocated and resources, (e.g. large out-patient clinics) in order to take detailed notes and give a detailed explanation as to possible complications etc.

The basic feedback from the legal profession was that the duty of care to the patient involved in a case does not change and it is up to the doctor to allocate adequate time for this. It is his problem if he doesn't.

In summary, there does not seem to be any mechanism in place to reduce the potential for litigation that is effective.

With the change in community attitudes and increasing amounts of settlement being awarded by the courts, it is obvious that during the next five years we will see significant problems occurring in this area.

In order to reduce the incidence of litigation, doctors are advised by all professionals to spend more time talking clearly with their patients and establishing clear agreements before proceeding with any treatment.

One of the most common criticisms coming from patient service, particularly in the area of general practice, is that patients are not feeling that the doctor is taking the time to talk to them.

It is a complex combination of time available, pressure of work and the fee system which is leading us to a situation where the faster we try to process patients to generate reasonable income, we significantly increase our chances of making a mistake and subsequently have an angry patient on our hands who has not had adequate discussion about the treatment.

This scenario is the classic situation where medico-legal claims for negligence are occurring.

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #87

Safe motoring,
Doctor Clive Fraser
doctorclivefraser@hotmail.com.

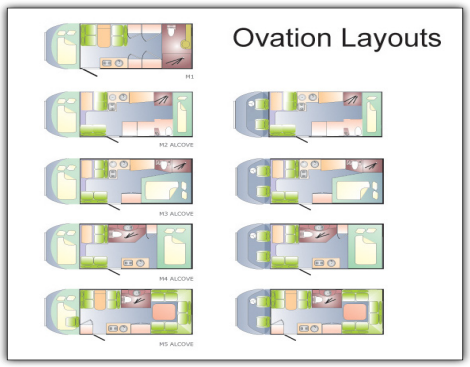
Fiat Ducato - Avan Ovation Motorhome.
"Take Me Home, Country Roads!"

It's that time of the year when many doctors are thinking of taking a holiday and hundreds of Senior Active Doctors who have been forced into retirement may be thinking of joining the hoards of grey nomads exploring Australia.

So the first decision medical travellers will need to make might be, "Will I buy a 4WD and a caravan or should I buy a motorhome instead?"

The caravan option promises the use of a vehicle for everyday use, but after that the arguments all stack up in favour of the motorhome. For starters motorhome don't need to be towed like a caravan, they are more spacious, they have more windows and a very big plus is that on many models you can see out the back when driving. So for much less than the price of a large 4WD and an up-market caravan, what will you get for about $110K in the motorhome market?

Well a colleague did all of the sums and placed an order for an Avan Ovation built on a Fiat Ducato chassis. The Fiat van chassis is also sold overseas as a Peugeot Boxer and a Citroen Jumper. It's ideal as a motorhome conversion because the rear wheels are widely spaced and there is a flat floor from the cabin all the way back to the living quarters.



Power comes from a 4 cylinder 3 litre turbo-diesel which drives the front wheels through a six speed automated manual transmission.

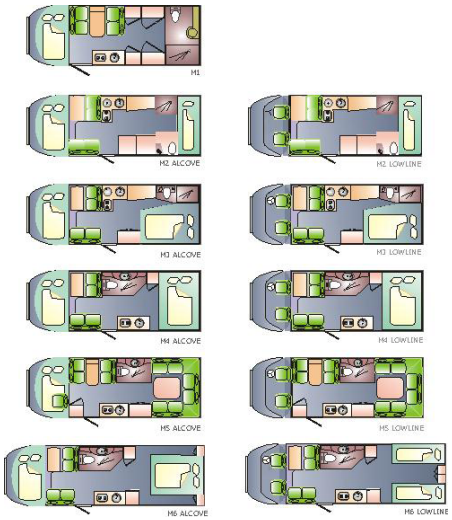
Economy is out-standing for such a large unit with 12.8 l/100km (22 mpg) being possible on the highway. This compares very favourably with a turbo-diesel Landcruiser towing a large caravan which could be expected to consume 30 l/100km (9.4 mpg) over the same terrain.

The Avan fit-out is considered to be at the economy end of the scale and this does mean that many of the fittings are rather flimsy and frankly under-engineered. The most glaring example of this is the Avan's floor which has already sagged in my colleague's vehicle. To save weight the floor is a sandwich of plywood and polystyrene which simply wasn't strong enough to do the job.

Avan are happily repairing this defect under warranty. It's worth noting that this rig isn't really up to the task of towing anything substantial either. The tow-bar doesn't seem to be bolted onto anything solid at the back and I definitely wouldn't recommend towing another vehicle behind. The brochure says it can tow up to 2.5 tonne with brakes, but I'd be surprised that with front wheel drive whether this is feasible.

Either way a towbar does spare the rather fragile rear end from being scraped on driveways.

A feature which was very neat were the block-out blinds that are built into the door pillars for privacy. All up the Avan Ovation is a step up from the residents' quarters and may be just the thing for doctors on the move.



Ovation Floor Plans

Fiat Ducato – Avan Ovation Motorhome

For: Stylish, affordable.
Against: Variable after-sales service.

This car would suit: Senior active doctors.
Specifications:

3 litre turbo-diesel
116 kW power @ 3,600 rpm
400 Nm torque @ 1,700 rpm
6 speed automated manual
Kerb mass 3092 kg
Gross vehicle mass 4000 kg
12.8 l/100 km (highway)
3 year 200,000 km warranty
$110,000 (approx depending on options).

Brisbane Gastroscopy + Colonoscopy

Adult Open Access Endoscopy Services

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Dr Derwin Williams
M.B., B.S., F.R.A.C.P..
Dr. Mark Norrrie
B.H.B., M.B., ChB., F.R.A.C.P., PhD.
Dr. Purmina Bhat
M.B.B.S (qld), F.R.A.C.P., PhD
Dr. Shamsul (Sam) Islam
M.B.B.S, PhD., F.R.A.C.P

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*Anaesthetist costs will be separately charged and of course any health fund excess is the responsibility of the patient.

Interesting Tidbits NATTY MOMENTS:

SMILE For A While & Lets Be JOLLY!

At least one of these should bring you a smile!

I have kleptomania, but when it gets bad, I take something for it.

Sometimes too much to drink isn't enough.

Heaven is Where: The Police are British, The Chefs are Italian,The Mechanics are German, The Lovers are French and It's all organised by the Swiss.
Hell is Where: The Police are German, The Chefs are British, The Mechanics are French, The Lovers are Swiss and It's all organised by the Italians!

My short-term memory is not as sharp as it used to be. Also, my short-term memory's not as sharp as it used to be.

Welcome to Utah. Set your watch back 20 years.

In just two days from now, tomorrow will be yesterday.
A bartender is just a pharmacist with a limited inventory.

The statement below is true. Statement above is false.

I may be schizophrenic, but at least I have each other.

I am a Nobody. Nobody is Perfect. Therefore I am Perfect.

KENTUCKY: Five million people. Fifteen last names.

Dyslexics Have More Nuf.

In Memorial With all the sadness and trauma going on in the world at the moment, it is worth reflecting on the death of a very important person, which almost went unnoticed last week.

Larry LaPrise, the man who wrote "The Hokey Pokey", died peacefully at age 93. The most traumatic part for his family was getting him into the coffin. They put his left leg in. And then the trouble started.

EXECUTIVE DIRECTOR REDCLIFFE HOSPITAL

Donna O'Sullivan

Redcliffe Hospital and University of Qld Collaboration

The School of Medicine at the University of Queensland formed the Northside Clinical School in 2008.

At the time, Redcliffe Hospital was host to around 20 third and final year UQ students each rotation, who spent time in several disciplines - Surgery, Medicine, the Critical Care Units, Obstetrics and Gynaecology and Paediatrics. In 2012 this number will rise to 27 students in each rotation, thanks to the introduction of new teaching facilities and the opening up of new Disciplines able to teach.

This year a new rotation, Medicine in Society, was formed and two more hospital units were opened to students – Palliative Care and Rehabilitation. At this point, three students have worked in these areas.

The recent expansion of the hospital's Paediatrics ward has boosted its capacity to take additional students. Paediatrics is one of the main areas of need within the School of Medicine so this is seen as a great benefit to the teaching of students in Queensland.

Dr Ian Yang, Head of the Northside Clinical School has been very supportive of the increase in opportunities for teaching collaboration between the hospital and the Northside Clinical School, which he heads. He recently stated "The Northside Clinical School is thankful with the excellent learning environment that the patients and staff have established at Redcliffe Hospital. We're looking forward to exciting developments for next year."

Redcliffe Hospital remains a popular choice for electives and although we have seen a drop off in the number of overseas students, the number of local students has increased with the introduction of First Year Electives in 2008.

Redcliffe hosts an additional 30 or so students each year on the electives program, with all the local universities represented.

In addition, new opportunities for placements have come with the refurbishment of the Medical Imaging Department.

Pleasingly, in 2012, nine of our medical students will return to Redcliffe Hospital as interns.

I am grateful to the clinicians and hospital staff who give their time so generously to teach the students and provide a positive environment for learning.

Donna O'Sullivan

Lillian van Litsenburg MP
Member for Redcliffe

Diabetes is a chronic disease that has begun to impact on our community but it is set to ripple through the community at a staggering rate.

A difficulty, particularly with type two diabetes, is that diabetics often look and seem well so people get the impression that diabetes isn't serious.

Because it takes some years for diabetic secondaries to develop diabetics themselves and those around them don't always take this disease seriously.

There are also commonly held understandings in the community that work against the positive long term management of diabetes such as; 'if you have type two diabetes its your own fault' or 'if you lose weight the diabetes will go away.'

As with smoking, managing diabetes in the community needs a long term strategic approach.

We need a strategy that is effective and that also targets children so they make life long choices about healthy lifestyles that will limit the chances of diabetes and other chronic diseases from developing into adulthood.

Effective and sustained education, increasing the price of cigarettes and carefully targeted legislation have significantly decreased the rates of smoking in the community.

What mix of strategies will limit the avalanche of diabetes that is hurtling towards us world wide, but particularly in developed countries, in the next twenty years?

We need the combined expertise of clinicians, allied health professionals, marketing professionals and legislators to defeat this scourge.

Perhaps the new medical Local health Network Boards will take on this challenge on behalf of their communities as they will have an ability to set the direction for health services in their regions.

Now is the time for us to act to slow or halt this avalanche. As with smoking the message will take some time to sow the seeds and reap the desired results.

Only a specifically targeted and sustained campaign across the whole community will achieve the strong results we need to retain a relatively contained level of diabetes in the community.

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Bluewater Square
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Cnr Anzac Ave & Sutton St
Redcliffe Q 4020

PO Box 936
Redcliffe Q 4020

Phone 3284 2667
Fax 3283 1073
Redcliffe@parliament.qld.gov.au

Introducing the Diabetes Care Clinic

The QML Pathology Diabetes Care Clinic is a specialised team that assists patients and practitioners in the management of diabetes.

- Run by Credentialled Diabetes Educators
- Appointments at various collection centre locations
- Group education for type 2 patients
- Claimable practice incentives for diabetes management
- Bulk billed service for type 1 and type 2 with EPC referrals.

For further information, please contact Margaret MacPherson, Medical Liaison Officer, on (07) 3049 4444.

QML Pathology.
Specialists in Private Pathology since the 1920s

Dr Marlon Radcliffe FRACP – Originally from South Africa, Dr Radcliffe has worked at Redcliffe Hospital as a full-time staff specialist general paediatrician since 2006 and is currently Director of Paediatrics.

Dr Simon Grew FRACP – Having completed his paediatric training in Sydney, Dr Grew has worked at Redcliffe Hospital as a part-time staff specialist general paediatrician since 2006. Dr Grew has now completed his Masters thesis on hereditary motor and sensory neuropathies.

Dr Vesna Markovich FRACP – Originally from Croatia, Dr Markovich completed her paediatric specialty training in Australia and New Zealand before joining the team at Redcliffe Hospital in 2009 as a full-time staff specialist general paediatrician.

Dr Jennifer Boseto FRACP – Hailing from the Solomon Islands, Dr Boseto undertook her paediatric specialty training in Queensland and joined Redcliffe Hospital in May 2011 as a part-time staff specialist general paediatrician.

Dr John McCreanor FRACP – Originally from New Zealand, Dr McCreanor has had a long association with Redcliffe Hospital as a visiting specialist general paediatrician since 1985.

Paediatric Central Referrals Office:
PH: 3883 7100
FAX: 3883 7901

http://www.gpqld.com.au/eHealth/eReferrals/#Templates

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOC
VICE PRESIDENT REPORT
Kimberley Bondeson

Medicare Locals and Local Hospital Networks.

AMAQ was fortunate enough to have Dr Bill Glasson, AO as one of the keynote speakers at the recent Prague AMAQ conference. He gave his initial talk on the Role of the Queensland Clinical Senate, which stimulated much response and debate.

Dr Glasson is a dynamic speaker, past AMAQ President and past AMA President. He is also chair of the Queensland Clinical Senate (QCS), established in 2008 which is a forum of a group of clinicians who formulate recommendations for Queensland Health on Health Care Delivery to Queensland. The Clinical Senate is comprised of 62 clinicians from Medical, Nursing, Allied Health and Academic backgrounds and meets three times a year.

He explained the theoretical role of the Local Hospital Networks, (LHN's) and their interaction with Medicare Locals (ML's).

LHN's are statutory authorities, run by a governing council with Queensland Health as the "Systems Manager". Medicare Locals are a company limited by guarantee, and set up under the Corporations Act. ML's are designed to establish strong care management capacity for patients with complex needs. The design is strongly dependent on input and co-operation between GP's, ML's and the LHN's.

It was interesting to hear what the initial design of the LHN's and ML's was intended for. We are currently seeing how, in practice, they are being rolled out.

At our own Redcliffe LMA, when ML's were first being discussed, it was decided, unanimously, to wait and see what the local ML's was all about. In theory, the board of the ML is comprised of seven members, of which only three positions can be General Practitioners. These GP's must come from a corporation. So, an interested sole general practitioner, for example, cannot be a member.

As it has turned out, even if any of the local GP's on the Redcliffe Peninsular wanted to be involved in the Medicare Local for the region, they were not given the opportunity to apply, even if they were eligible, and belonged to e.g. a corporate practice. There was no advertising, and it appears that the current GP's on the board of the Medicare Local were rolled over from the old Division of GPs.

There is a gap between what was initially intended in the new design, what the actual doctors on the ground are doing, and how it is being rolled out. This generated some very stimulating discussion at the conference. Most GP's are currently already managing patients with complex medical needs. In fact, I do not know of any GP who is not doing this.

In practice, the Medicare Local for this region, have turned up at one of the GP Practices, and asked to take over their Team Care Arrangements. This effectively would put in another layer of bureaucracy. The ML's also distributed a pamphlet which stated that they would help arrange referrals for e.g. a diabetic patient to see a podiatrist. Why would you interfere in what is already in place and that is working well? This would increase the waiting time and paperwork for a referral, not assist with it.

There is a huge gap between the theoretical design, its intention, and what is being implemented. Of course, it is in its early infancy, so we shall just have to wait and see.

"It could be that the devil is in the detail or a change in politics could see that the entire concept is cancelled"

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SENATE MENTAL HEALTH INQUIRY OUTCOME REFLECTS HUGE WORKLOAD AND MISINFORMATION

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA President, Dr Steve Hambleton, said today that this week's messy and divided outcome from the Senate Community Affairs Committee Inquiry into the Commonwealth's funding and administration of mental health services reflects the enormity of community interest in mental health, and the confusing and misinformed input from some key stakeholders.

The Inquiry received over 1500 submissions, many of which focused on the Government's changes to mental health funding announced in the 2011/12 Budget, with over $400 million cut from Medicare funded GP mental health services.

Dr Hambleton said the Inquiry's majority and minority reports place further doubt on the rationale for the Government's cuts to mental health services accessed through general practice under the Better Access program, which took effect from this week.

"The Government's changes have clearly caused significant concerns in the community and this is reflected in the divided opinions of Committee members, with the Inquiry unable to reach a consensus view.

"Indeed, the Government issued a minority report.

"The Inquiry clearly acknowledges that the Budget cuts will have an immediate impact on patients because alternative services being funded by the Government are not currently in place.

"It is clear that the key role of GPs in helping people with mental illness was not fully appreciated or understood by some Committee members.

"The AMA is particularly concerned that the Department of Health and Ageing did not properly assist the Committee with the evidence it provided.

"The Department told the Committee that GP mental health care consultations involved the same amount of work as a normal GP consultation, which is an insult to hardworking and highly skilled GPs.

"It would have been more appropriate for the Department to have brought the Committee's attention to a more appropriate comparison - GP management plans for physical illness.

"Medicare rebates for mental illness will now be lower than those for physical conditions."

Dr Hambleton said that the minority Coalition report correctly identified the cuts to Medicare rebates for GP mental health services as being a cost saving exercise implemented with no genuine consultation with GP groups.

The AMA will continue to lobby for restoration of the Better Access funding and will monitor the effect that the Government's changes will have on some of the most vulnerable patients in the community.

4 November 2011
CONTACT:
John Flannery
Phone: 02 6270 5477
Mobile: 0419 494 761

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION MEMBERSHIP

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

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

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

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CHANGES TO CLASSIFIEDS

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

Classifieds will be published for a maximum of three placements.

Classifieds are not to be used as advertisements.

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

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription due for the period: 1st July 2011 to 30th June 2012

Dear Doctor

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

As this is now June 2011 your subscription to cover until the 30th June 2012 will be $100.
Doctors-in-training and retired doctors are invited to join at no cost. This subscription not only entitles you to ten (10) dinner meetings but also to a monthly magazine. Contributions and suggestions on topics and/ or speakers are very welcome.

Please can you endeavour to pay your subs by internet banking as it is so much easier for all concerned, saving you writing cheques and us having to bank them? You will receive your receipt by email if you supply your email address to me on **GJS2@Narangba-Medical.com.au.**

Yours sincerely

Dr Peter Stephenson
Treasurer

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION INC.

ABN 88 637 858 491

Note: **Two Medical Practitioners from the One Family Qualify for a $25 Discount each**

Tick box **1. ☐ One Member ($100) 2. ☐ Two Family Members ($150)** **(Complete BOTH sets of details)**
3. ☐ Doctors-in-training and retired doctors: Free

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

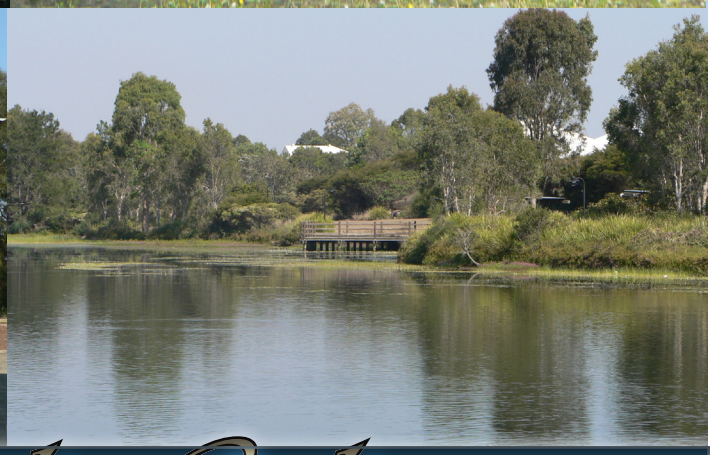
METHODS OF PAYMENT:

1. PREFERED **INTERNET BANKING**
2. PAYMENT BY DEPOSIT SLIP: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. ENCLOSED PAYMENT: (Note: Member Subscription Form on website for you to type directly into and email)

i) **Complete form & return: c/-QML or Redcliffe & District Medical Assoc Inc. P O Box 223 Redcliffe 4020**

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

Where We Live And Work



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