RDMA
RDMA & NLMA's Joint Newsletter

Newsletter
NOVEMBER 2014

Remembrance Day

See Where We Work & Live Remembrance Pictorial on page 20

President's Report Dr Kimberley Bondeson

Seasons' Greetings and a very Happy New Year wish to all.

This year, we have our self-funded Christmas Party at our regular meeting venue the Golden Ox in addition with their festive support and donation.

This means we should thoroughly enjoy our Christmas Party, with Christmas Carols by the Redcliffe Choir. Other music provided by "Music by Denis", and "The Three Amigos", which will be a treat!

This week holds a very important date of commemoration from the War to end all Wars: Remembrance Day. I did not come from a military family and was educated at an International School overseas, which had 400 students, encompassing 40 different nationalities. Arrival at school was met by armed security, with numerous different Diplomatic Ambassadors' family members arriving under security at the School.

Therefore, when it came to details of Remembrance Day, and World War 1, I was at a loss.

During the last meeting, the topic of conversation turned to the Villers-Bretonneux battles. Not having a real understanding about this topic, I asked my husband whose father was in the Military to write a short synopsis about these battles: There are many things as Australians that we associate with World War 1. Gallipoli (obviously), ANZACs, Remembrance Day, Trench Warfare, dislike for Pompous British Officers, Mateship, and Loyalty to name a few. Less well known being the two Battles fought for and over the Village of Villers-Bretonneux.

The one, that is embedded into our psyche the most, being the Gallipoli Campaign. For just under 9 Months from April 1915 until January 1916, Australian, New Zealand, British and Allied troops attempted to tie up the Ottoman Empire military, to help relieve some of the pressure exerted against allied countries suffering from lack of trade.

This lack of trade of course affected food supplies. Trade had effectively halted in the West because of the comparatively new form of warfare: Trench Warfare.

During this Campaign, Australia suffered close to 9,000 deaths, with almost 20,000 injured. These figures do not include the Death & Casualties suffered by our Allies. Prior to the Gallipoli campaign, fighting had been under way on the Western Front since mid to late 1914. By Western, we mean the North of France-Belgium region. This was a time of hand to hand Trench warfare, where Victory was sometimes measured in taking a few metres in a day, (unfortunately as so often happened, losing that ground over the next couple of days). Backwards and forwards. Living in muddy trenches, on top of your mates, constantly terrified of Mustard Gas and that dreaded whistle signifying another "over the top".

There is no way for me, someone three generations removed, to comprehend or even imagine the terror & hell that life had become for the men in the Trenches.

The first battle of the Village of Villers-Bretonneux (30 March-5 April 1918) was part of the wider first battle of the Somme and saw the Germans pushing to capture the city. From there, Artillery could be used to shell the Strategic centre of Amiens (close to breaking through on their way to Paris). The Germans launched an attack on the City, and after heavy fighting gained the upper hand.

Cont Page 5:

RDMA & NLMA's Joint Newsletter WELCOME FROM Dr BOB BROWN President Northside Local Medical Association

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

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RDMA 2014 MEETING DATE CLAIMERS:

For all queries contact Margaret MacPherson
Meeting Convener: Phone: (07) 3049 4444

CPD POINTS & ATTENDANCE CERTIFICATE AVAILABLE

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

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

RDMA NEWSLETTER DEADLINE

Advertising & Contribution is 14th December 2014
Email RDMAnews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

NLMA 2014 Bi-MEETING DATE CLAIMER:

For all Northside LMA Meeting & Membership queries contact:
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Website and Link:
Northside Local Medical Association Website
Link: http://northsidelocalmedical.wordpress.com/

Meeting Times: 6.45 pm for 7.15 pm

2014 Dates:

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

2015 Date Claimers:

1	10th February 2015	2	14th April 2015

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NORTHSIDE LOCAL MEDICAL ASSOC PRESIDENT
Dr Robert (Bob) Brown

I wish to devote my article to a particular doctor who is soon to retire from the position of Principal Medical Officer in the Department of Veteran Affairs.

I have included a passage and photograph of Graeme taken from the Defence Health Foundation website.

I can only say that the attached bio, although accurate, understates the impact that Graeme has had on Veterans' health and the Australian Defence Force, but also the practice of medicine, especially General Practice. Graeme has the capacity and will, to look at the 'big picture' as well as deliver. His unswerving support of the Local Medical Officer (LMO) and of the relationship between the LMO and Veteran has been instrumental in delivering more and better care of Veterans as well as the Australian public at large.

I wish Graeme a happy and healthy retirement from me personally but also from The Brisbane Northside Local Medical Association, and I'm sure a large part of the Australian medical fraternity who know and admire him.

Well done, Graeme.

Dr Graeme Killer
AO M.Sc., M.B.B.S., Dip Av Med., D.I.H., F.A.F.O.E.M., F.A.F.P.H.M., A.R.A.C.M.A

Principal Medical Adviser Dr Graeme Killer is the Principal Medical Adviser to the Repatriation Commission.

He trained as an Occupational Physician and served for 23 years in the Royal Australia Airforce (RAAF) including overseas postings to Malaysia and the United Kingdom. He served in Malaysia during the Vietnam War and was involved in aeromedical evacuation.

On his retirement from full-time Defence service in 1990, he was Director of Environment Health for the Australian Defence Force (ADF).

He has been Principal Medical Adviser to the Department of Veterans' Affairs (DVA) since 1991 and has taken a leading role in departmental initiatives in the quality use of medicines.

He is a Member of the Repatriation Pharmaceutical Reference Committee (RPRC), Chairman of the Editorial Committee and Consumer Reference Group for the Veterans Medicines Advice and Therapeutic Education Services (MATES) Program.

He pioneered the introduction of care planning and preventive annual health assessments for older Australians and initiated the Health Links Program between the Departments of Defence and Veterans' Affairs. He has extensive health care interests including occupational and public health and aged care. He maintains part-time clinical practice and has been personal physician to Prime Ministers Keating, Howard and Rudd and has a similar role with Government House, Canberra.

He was made an Officer of the Order of Australia in 1999 for his service to the veteran community. (Defence Health Foundation website).

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AUSTRALIAN MEDICAL ASSOCIATION QLD PRESIDENT
Dr Shaun Rudd

Dear members,

It's hard to believe that there's only one newsletter left before the AMA Queensland office packs up for the holidays. This year has been full of great accomplishments: fighting for better contracts for SMOs, working with the government to develop a more viable co-payment model, and continuing to bring new services and offerings to our members.

While the year is winding down, there is still work to be done. As you have probably seen in the media, concerns have been raised recently about recent Metro North staff changes and ongoing uncertainty surrounding tenure. Doctors are also concerned by the serious nature of current allegations at the executive level relating to probity issues.

AMA Queensland has been and will continue to monitor developments and support our members as these ongoing issues are sorted out. We will be working with the local Medical Staff Association and working to facilitate resolution where possible. In the meantime, we encourage members to call us with any of their concerns.

Major hospital developments have not just been isolated to Brisbane. We recently saw two senior doctors stood down in Cairns after they spoke with the media about a recent Ebola scare.

The incident in Cairns was a learning experience for all staff involved as well as medical professionals around the country. It's a shame to see two doctors suspended when they could and should be helping the patients who need them, and we will continue to support these members with the goal of reinstatement.

Last month I mentioned concerns over expanding the roles of allied health professionals. In recent months, AMA Queensland has continued to consult with stakeholders and develop a position statement that addresses the scope of allied health professionals.

We will continue to advocate for a system that sees doctors and other medical professionals working together to support patients rather than substituting each other and will keep members updated on any new developments.

In addition to advocacy work, we've brought a number of new events and offerings to members. With intern placements starting soon, a key concern has been ensuring we are supporting our young members during this time in their career. We recently held our Brisbane Intern Readiness Workshop and will be bringing this workshop to the Gold Coast and Townsville in the next few weeks.

We work to support members at all stages of their careers, but it's always special to welcome and support new members of the medical fraternity. This will be a key priority in 2015 as we roll out a new resilience and wellbeing program.

Keep an eye out for updates about new programs, events, and offerings for 2015 on www.amaq.com.au.

Sincerely,
Dr Shaun Rudd
AMA Queensland President Queensland

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President's Report Dr Kimberley Bondeson

Continued:

Australian troops of the 9th Australian Brigade were brought down from Belgium to help shore up the line in early April. It was not until a counter attack on the afternoon of the 4th of April by the Australians and British that the German attack broke up.

The Australian Brigade suffered 665 casualties out of 2,250 men.

The second battle of the Village of Villers-Bretonneux (24-27 April), involved the Germans taking the City by coming from the direction of Amiens. This was initially accomplished with the assistance of their A7V Tanks, (as an interesting footnote, this was the first occurrence of a Tank versus Tank battle ever.)

A counter attack by two Australian & one British Brigade retook the city on the 25th of April. The Australian casualties for this four-day period were close to 2,500, with the Germans suffering between 8,000-10,000 causalities. (Again, these figures do not include those suffered by our Allies.).

The Allies were finally able to push the German line back, retake the city proper, and hand it back to the Villagers.

The Village remained in Allied hands till the end of the War with the four day Battle being considered a great success for Australian Troops.

We have commemorative days for our ANZACs, and for the end of the War (Remembrance Day).

In both cases, we are recognising the great Sacrifices everyone suffered, the Mateship and Loyalty endured and celebrated by our Troops.

We should also take some time for ourselves to remember those who fought, fell, & succeeded in both Battles for the Village of Villers-Bretonneux.

Kimberley Bondeson

President
Redcliffe & District Local Medical Association

2015 Date Claimers

RDMA 2015 MEETING DATES TBC Early 2015

February 24th Tuesday

March 25th Wednesday

April 28th Tuesday

May 27th Wednesday

June 30th Tuesday

July 28th Tuesday

AGM August 26th Wednesday

September 15th Tuesday

October 28th Wednesday

Networking Function November 27th or December 4th Friday (TBC EARLY 2015)

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

SCOPE OF PRACTICE

Wearing another hat, I was recently asked to give an opinion about delegated authorities. If I order somebody else to do a medical task that the person has been trained to do, can that person legally do that task?

The answer, in a more innocent day, used to be pretty clear. If the person had been given adequate training, and especially if I knew the person's capabilities and trusted them to do that job, then I could give them the instruction, and they were well protected legally if they obeyed my instructions.

Those innocent days are gone. The legal position that I was asked to give advice on turned out to be far less clear than it was even a decade or so ago (and in retrospect it was fairly murky even then).

Translating that into everyday modern practice, we are bedevilled today by legal complexities.
In general practice, we are used to giving instructions to our practice nurses. But some practice nurses are RN's and some are EN's. Do their employers really understand the limitations of their respective scopes of practice?

Some idiosyncratic practices train their practice nurses to perform tasks that most practice nurses might hesitate to do. Look at the emerging single-purpose practices such as skin clinics, sports medicine clinics, or womens' health centres, that all practice narrowly but still under the rubric of primary care. Are their practice nurses practising within their recognized scopes of practice?

In specialist practice, nurses perform tasks which are increasingly specialized, tasks which their employers trained them to perform but which were not taught in their nursing training. Nurse practitioners are today being trained as endoscopists and anaesthetists. How far can "scope of practice" be stretched before it will break?
Pushing the boundaries of "scope of practice" even further, the medical profession watches with alarm as pharmacists are urged to test the limits more and more. Over the past few years, we watched pharmacies promote their skills in diabetes and asthma management, and perform ultrasound examinations on heels to diagnose osteoporosis. Few pharmacists took the risk inherent in providing sick notes for employers, but the opportunity was well publicized at the time. Most alarmingly, they are probing deeper and deeper into the territory of mass immunization.

"Scope of practice" is a mobile definition. I am (I hope) competent at performing tasks, managing technologies, and prescribing medications that were undreamed-of when I graduated four decades ago.

My scope of practice has expanded and deepened over those years. Nobody has re-credentialled me – and that prospect is an inevitable part of the future of medicine.

But while I am confident that I am practising within my capabilities, who is really keeping a close watch over the scopes of practice of those who work beyond my control?

The opinions expressed herein are, as always, those of your correspondent,

Wayne Herdy.

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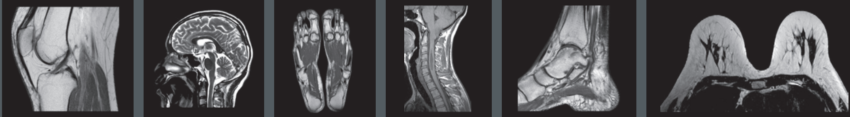

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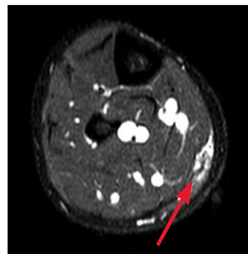
Tennis Leg

Findings



Fluid and high signal is noted surrounding at the musculotendinous junction of the plantaris and appearances are consistent with a tear. The underlying soleus and gastrocnemius muscles are within normal limits.

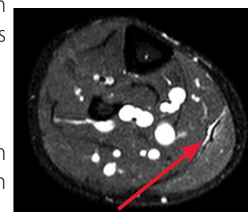
Diagnosis

Plantaris tear (tennis leg)

Discussion

- Epidemiology

Although classically seen in people who play tennis, it can also be induced by playing squash, skiing and athletics. Therefore, it typically occurs in active individuals, more frequently in middle age. The same injury can also occur with more sedate activities, such as running to catch a bus. Extension of the knee and forced dorsiflexion of the ankle seem to be the most frequent biomechanical causes for the injury.



- Clinical presentation

The presentation is one of sudden sharp pain in the posterior aspect of the calf, associated with a sensation of something 'snapping' within the calf. This is associated with focal tenderness and swelling. A focal 'gap' can sometimes be felt early on (prior to swelling) at the sight of the tear.

- Pathology

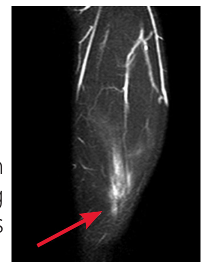
Although tennis leg is fairly common, whether it represents a single entity or not is still debated. The two mechanisms identified are:

1. Rupture of the plantaris tendon (now thought to be a less or uncommon cause).

2. Tear of the myotendinous junction of the medial head of gastrocnemius.

Both findings have been found in isolation or together.

- Differential diagnosis
  - Deep Vein Thrombosis
  - Ruptured Baker's cyst



- Treatment and prognosis

Treatment is usually conservative and the condition self limiting. Only in cases where severe swelling leads to a compartment syndrome does surgical fasciotomy become necessary.

Services:

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Interventional/Procedures | Ultrasound | Nuchal/Obstetrics | MRI
Echocardiography | OPG | PA / Lat Ceph | Bone Densitometry

REFERENCES
http://radiopaedia.org/articles/tennis-legappendagitis

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AMAQ BRANCH COUNCILLOR REPORT
GREATER BRISBANE AREA
Dr KIMBERLEY BONDESON

National Residential Medical Chart

We have good news for all those doctors who prescribe medications for their patients at Nursing Homes.

The Queensland Government has just allowed the National Residential Medication Chart to be available in Queensland. (also in Victoria).

This enables supply and pharmaceutical benefits scheme (PBS) claiming without a separate PBS prescription.

The Australian Government has passed changes to allow PBS claiming to occur. At Medical School, I recall being taught that a registered doctor in Australia could write a prescription on any piece of paper, and it would be honoured and dispensed by a pharmacist.

Finally, the Government has caught up with this, and sensibly realised that:
double writing, and in some cases quadruple writing (the patients medication chart in the nursing home,
the patients hand written chart in the nursing home,
the patients computer record in the nursing home and finally,
the computer copy in the doctors surgery -
and then finally, the actual either handwritten or computer written prescription itself - that is actually 5 copies...)

The Australia Government has passed changes to the National Health Act 1953 to allow PBS claiming to occur.

It excludes requirements for controlled drugs (schedule 8).

All medications are valid for dispensing if dispensed by a pharmacist for a maximum of 4 months from the first date a medication is ordered on the medication chart of up to the expiry date that appear on the front page of the medication chart, whichever comes first.

Phone order by doctors at Nursing Homes must be rung through to the pharmacist and followed by a traditional script.

A medication chart which has the name of the patient, their date of birth, address, facility, name and qualification of prescribing doctor along with the doctors address and date of prescribing, can be faxed, scanned and faxed or scanned and emailed, and is deemed appropriate.

Great! Finally, common sense. Won't it be good to actually have the hospital doctors and specialists who make changes to patients medications whilst an inpatient or an outpatient write the medication changes on ONE form, so we all know what is occurring. Instead of waiting for the discharge summary from the hospital, which often is sent to the wrong facility, the wrong GP, and occasionally to the wrong patient...?

One potential hiccup I can see is Nurse Practitioner prescribing. In certain nursing homes, which I will say are fully covered by General Practitioners during the day with an after-hours service, or the General Practitioner themself, are "moving Nurse Practitioners in"- called in by unknown persons to see a patient as the GP is "unavailable". They then fiddle with the patient's chart and management plan - whether it is something simple like a UTI, and without the knowledge of the patient's renal history, prescribe inappropriate medications (antibiotic). Much too many times I have seen a random MSU sent off by nurses in an asymptomatic patient, and a request for oral antibiotics. My first question is "does the patient have any symptoms". If not, let us examine the patient and repeat the urine MCS and see if it is indeed a genuine and treatable Urinary Tract Infection. My impression is that the nursing homes are scrabbling for government funding, and trying to claim more funding venues.

However, the definition of a "Nurse Practitioner", as I understood it, is a senior nurse who works in conjunction and under the supervision of a Medical Practitioner - as I have done on numerous occasions with wonderful registered nurses in rural and remote locations.

Co-Payments
Now on to the Co-Payment issue. It appears that this item will not be able to get through the senate. However, the concern at the moment, is that the government will ignore the Senate and public opinion, and sneak the co-payment in, simply introducing it without the approval of the Senate or the public.

We see this occurring intermittently with the Medicare Item Numbers being deleted or Item Descriptors being "changed" -

Cont Page 9:

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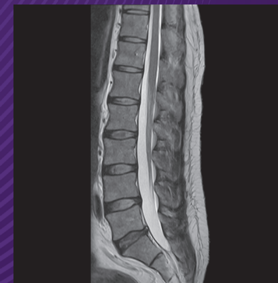

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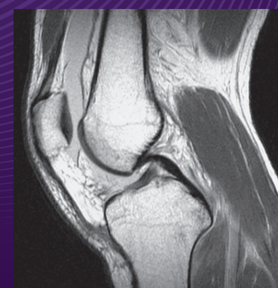

TRUSTED ANALYSIS

AMAQ REPORT GREATER BRISBANE AREA Dr Kimberley Bondeson Cont:

by a simple meno, which simply benefits the government, decreases patients' rebates, and for those doctors who bulk bill, their income.

It is obvious that the introduction of a co-payment will have unintended consequences to the government - and will not in fact save them any money, but end up costing them more for example, the implementation of chasing the extra money from patients. How are General Practitioners going to do this? What are the implications for their software, and extra staffing? How are Emergency Departments going to cope with the extra input of patients trying to avoid the fee? Figures have actually been calculated for an Accident & Emergency Department to see and treat a simple GP type patient, which is approximately $600 per patient. Waiting 4 hours to get that free prescription is actually quite expensive. Considering they are avoiding paying a $7 gap payment. For patients who simply do not have any money, they have no choice.

We will continue to Watch this Space.

Dr Kimberley Bondeson,
AMAQ BRANCH COUNCILLOR,

Job Vacancy
A part-time *(with view to full time if required)* VR Family Doctor for the Narangba Family Medical Practice (www.narangba-medical.com.au) as one of our doctors (Dr. Orr) has left to specialise.

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MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #114
Safe motoring,
doctorclivefraser@hotmail.com.

Car Servicing and The Hippocratic Oath
"At Your Service"

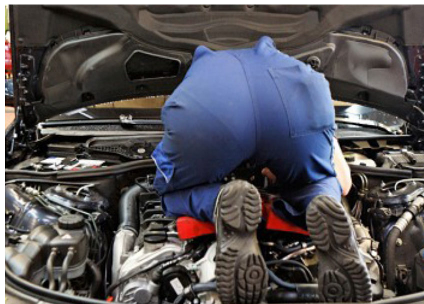
Car manufacturers spend millions every year on developing systems and software that keep new cars on the road. It is therefore not surprising that they might be motivated to take steps to protect their intellectual property.

Hollywood and record companies have taken a financial battering because of the unlawful downloading of movies and music so why wouldn't car companies try to maintain ownership of their data.

But by refusing to share all of this information, owners may then be obligated to take their vehicles back to the dealer for even the most basic repairs. I've experienced how annoying this is first-hand when my car simply got a flat battery.

My vehicle lowers the windows slightly when the doors open so when my car senses a low voltage from the battery my windows just keep coming down. Not so good if it's raining or you want to secure the vehicle because you can't get it started. Fortunately, my road-side assist got me going again, but they couldn't reset the air-bag warning light which is the default warning for any fault with my vehicle.

So off to the dealer I went for half a day and $100 to reset the service light. But there are lots of places in Australia that don't have a dealer for every type of vehicle on the road. And as a key differential from movie and music piracy, independent repairers have always offered to pay for the use of the information.



But that still hasn't produced consensus between the manufacturers/importers represented by FCAI (Federal Chamber of Automotive Industries), the dealers represented by AADA (Australian Automotive Dealer Association) and the independent repairers represented by AAAA (Australian Automotive After-market Association).

FCAI and AADA last month pointed out that a 2012 review by CCAAC (Commonwealth Consumer Affairs Advisory Council) found that "there does not appear to be any evidence of systemic consumer detriment regarding the sharing of service and repair information in the automotive industry". From that you might infer that it was all sorted, but CCAAC also recommended that, "the automotive industry develop, within a reasonable period of time, an outcome that ensures there is a process for independent repairers to access repair information".

Two years later that hasn't occurred and FCAI and AADA still claim that they are "the only organisations that appear to be making progress on this matter" with a voluntary code.

AAAA have fired back with accusations that FCAI has "walked away from the negotiation table" and that the voluntary code is "biased and inadequate". FCAI have accused AAAA of "abandoning the process", a little unfair I feel when they released the voluntary code without consulting the other parties. AAAA say that restricting access to the information is anti-competitive and restricts the owner's choice of repairer.

As a peace offering VACC (Victorian Automobile Chamber of Commerce) has offered to make their extensive repair information library available to all independent repairers in Australia. Apparently the VACC call centre currently answers 98 per cent of received technical enquiries.

AADA say that, "It's therefore difficult to understand what repair information AAAA wants, which is not readily available at a small cost, or provided as part of being a VACC member".

That all looks like smoke and mirrors to me because AAAA have clearly said that they, "are seeking access to the information, tools and training required to diagnose faults, repair and maintain today's technically complex vehicles under 'fair and reasonable' commercial terms".

And just getting back to that 98% figure I'd bet that 2% relates to the information about the flux capacitor which we all know is a very important component in modern cars.

Whilst I'm not a betting man I'm putting my money on the little guys at AAAA who have said that, "as these are the same multinational car companies operating in the Australian market, we must ask the FCAI: 'Why do you believe Australian consumers do not deserve the same rights as car owners in Europe and North America?'

As doctors we are spared these silly arguments about who owns the fleas on the dog.

After all the Hippocratic Oath states that, "I will teach them my art without reward or agreement; and I will impart all my acquirements, instructions, and whatever I know, to my master's children, as to my own; and likewise to all my pupils, who shall bind and tie themselves by a professional oath, but to none else".Enough said!
Safe motoring,Doctor Clive Fraser

RDMA October Meeting 28.10.2014 Sponsor: GSK Pharmaceuticals.

Chair President Dr Kimberley Bondeson Speakers: Dr Sumat Kevat, Rhuemotologist Topic: Prolia: (denosumab) Making an Impact in Osteoporosis Management

CLOCKWISE; Speaker Dr Sumant Kevat. New Member Nick Balakrishnan. Drs Sumand Kevat and Fred Bittar.

Primula and Nick Balakrishnan.

BELOW: Sponsors: GSK Representatives: Nicole Robertson & Pam James.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

CHRISTMAS PARTY

Date: Friday 5th December

Time: Bring your partner and join us for the final meeting of the year
7.00pm for 7.30pm

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

Cost: Members Free, Members' partners $60
Non-members $100, Non-members' partners $60

Music: Music by Denis
The Amigos

Dress: Smart Evening Wear

Sponsor: Redcliffe & District Medical Association Inc. & The Golden Ox Restaurant

Meet & Greet: Dr Shaun Rudd (President – AMAQ)

RSVP: e: margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 28th November 2014

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Retirement Notice – Dr Jonathon Davies

This notice is to advise that Doctor Jonathan Davies, General Surgeon, will be retiring from 23rd December, 2014. I wish to take this opportunity to thank the Medical Fraternity of the Redcliffe & District Medical Association for their support over the last 33 years.

It has been a pleasure and an honour to care for the many patients referred to me over the years. Dr Roderick Borrowdale and Dr Hugh McGregor, General Surgeons, would be happy to continue in the care and management of Dr Davies' patients.

Dr Jonathan Davies

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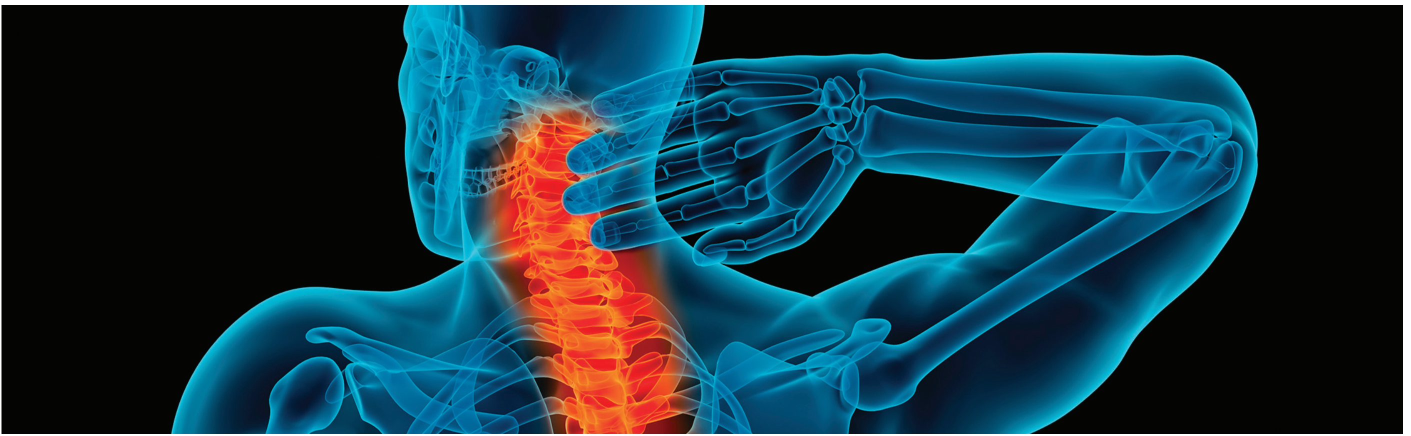

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The Medical Journal of Australia • MJA
MEDIA RELEASE

GOVERNMENT MUST REVERSE MEASURES TO HELP RURAL GPs

EMBARGOED UNTIL 12:01am Monday, 17 November 2014

THE Australian Government must reverse its recent decision to dump the highly successful general practice placements program if rural areas are to ever get equal access to quality primary care, says the author of a Perspective published in the *Medical Journal of Australia*.

Dr Ian Kamerman, president of the Rural Doctors Association of Australia, and director of Northwest Health in Tamworth, New South Wales, said measures taken by the Coalition Government since the 2014 Budget were hindering efforts to encourage young doctors to practice in rural settings.

“Regardless of a location’s attractiveness, without appropriate support services and incentives, the next generation of doctors is more likely to gravitate towards urban general practice or specialist practice than towards the bush”, Dr Kamerman wrote.

“This is worrying, given that the iconic rural doctors who have been the backbone of rural medical care for decades are fast approaching retirement.”

Dr Kamerman said Budget measures such as the dismantling of the General Practice Education and Training (GPET) from the end of this year, and the scrapping of the Prevocational General Practice Placements Program (PGPPP), were damaging.

“Rural practices and medical graduates need clarity as to how rurally based GP training will be undertaken going forward”, he wrote.

The proposed $7 copayment also has the potential to hit rural practice hard, further discouraging graduates from moving to the bush.

“Should the [copayment] lead to a significant drop in the number of consultations, many practices will decide against taking on GP registrars, leading to a significant drop in the availability of GP training opportunities”, Dr Kamerman wrote.

Dr Kamerman welcomed the changes to the ASGC-RA announced recently which until recently penalised the shift in the health system’s focus from specialist medicine and acute care beds to “better supporting generalist and team-based community care that is accessible to all Australians, regardless of where they live”.

A podcast with Dr Ian Kamerman is available at www.mja.com.au/multimedia/podcasts

Please acknowledge the Medical Journal of Australia (MJA) as the source of this article

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

The statements or opinions that are expressed in the MJA reflect the views of the authors and do not represent the official policy of the AMA or the MJA unless that is so stated.

CONTACTS: Dr Ian Kamerman 0427 241 900
Ms Jenny Johnson CEO RDAA 0429 931 120
Mr Patrick Daley, Media Unit 0408 004 890

RACGP

Healthy Profession.
Healthy Australia.

8 October 2014

Dr Mal Mohanlal
Beach Medical Clinic
135 Margate Parade
MARGATE QLD 4019

13 OCT 2014

Dear Dr Mohanlal,

Thank you for your letter to the RACGP raising your concerns regarding the collection of a patient's ethnicity in their medical record. We agree that this is an important issue.

The RACGP *Standards for general practices* (4th edition) (the Standards) notes that practices in all clinical settings should work towards identifying and recording the cultural background of all patients. It is important to note that this is not a mandatory indicator within Criterion 1.7.1 of the Standards, and is therefore not required to achieve accreditation. However, it is suggested that practices collect this information because cultural background can be an important indication of clinical risk factors and can assist GPs in providing relevant and appropriate care.

This suggested indicator, designed to facilitate appropriate care, should also be viewed in the context of the mandatory indicators in Criterion 2.1.1 of the Standards, which require that practices provide respectful and culturally appropriate care for patients. This includes the mandatory indicator to prevent discriminating against, or disadvantaging, patients in any aspect of access, examination or treatment (Indicator A) as well as the non-mandatory requirement of identifying important or significant cultural groups within the practice and outlining strategies that are in place to meet their needs (Indicator G).

The RACGP Curriculum for Australian General Practice also ensures that general practice training includes cultural competence. That is, the ability to work competently and effectively in encounters with people from different cultural backgrounds to ensure the delivery of high quality general practice care.

In particular, the Training Outcomes related to Multicultural Health under the RACGP Curriculum for Australian General Practices reflect this through requiring that GPs:

- Learn about illnesses that may not be common within the general community but occur among those from culturally and linguistically diverse backgrounds.
- Understand how social and environmental determinants of health influence quality multicultural general practice care, including:
  - diseases from the country of origin of the patient – nutritional deficiencies; health effects of war, torture and trauma; infectious diseases
  - diseases relating to migration; refugees may spend many years transiting countries
  - diseases of settlement – nutrition and lifestyle diseases of host country

The Royal Australian College of General Practitioners
100 Wellington Parade, East Melbourne, Victoria 3002 Tel +61 3 8699 0414 Fax +61 3 8699 0400
www.racgp.org.au ACN 000 223 807 ABN 34 000 223 807

Burgundy, France

By Cheryl Ryan

A relaxed and serene holiday amid beautiful valleys and scenic backdrops with a glass of world famous wine in your hand; and plenty of things to keep you engrossed while you are vacationing at this most prosperous region of France, it is none other than Burgundy!

A local region of east central France and south east Paris, Burgundy is abundant in natural beauty and rich historical architecture offering beautiful roman churches, castles, and buildings. Not to forget, its world famous wines too.

For Wine Lovers
From the world famous wines like Vosne-Romanee, Chablis, Rully and Pouilly Fume, you get to taste them and experience a lovely walk through the vineyards while you relish the taste and magnificent landscapes. Wine experts make your wine tasting experience even better by sharing the secrets of their vineyards and wines. As the wine routes are dotted with restaurants, there is plenty for you to stir up your taste buds!

For Nature lovers
The Morvan National Park is the place to be if you admire nature and want to spend time with natural beauty all around you. From the beautiful singing rivers to lush green rolling hills and calm lakes, this park is a must-visit for nature admirers. Some of the must-do activities include fishing, mountain biking, horse riding, or simply getting lost in the natural beauty!

History and Architecture-bring it on!
Burgundy brings to you a bountiful of history from the Paleolithic period to the Glorious age, showcasing the historical richness in its Abbeys and churches, Chateaux, medieval villages, and museums. Home to Gothic and Romanesque architecture, L'Abbaye de Cluny, St. Lazare, and Basilique Sacre-Coeur, Paray le Monial are not to be missed. A visit to Brancion, the most real medieval village will awe you with its beauty and mystery. Burgundy has plenty of Chateaux in parkland open for visitors all through the year. Some of the must visit include Bussy-Rabutin, Cormatin, and the military glory of Marshall.

There are many museums that show case motorbikes, aircrafts, and the Resistance movement. A must do on itinerary for people of all ages! Some of them include Chateau de Savigny-les- Beaune, Bibracte, and Musee des Beaux-arts!

We have highlighted the must-do things for you to ensure you get the best holiday experience in Burgundy:

Visit Beaune: The capital region of wine in Burgundy that offers many mesmerizing wine tasting tours through the vineyards of Beaune. It is a best place to taste wine in entire France. And, how could we miss it?

Within a short distance of Beaune lie Chateau de Pommard and Chateau de Meursault showcasing cellars and bottles with some of the prestigious white wines. Delight for wine lovers indeed!

Pamper your "old soul" by visiting some of the best medieval villages of Burgundy. The ones on list include: Montreal village, on the brink of a hill that overlooks the beautiful Serein valley and Brancion with a castle on its entrance looking picture perfect!

Rent a boat and go on a Saone river cruise to enjoy the mesmeric beauty all around and enliven all your senses.

www.123Travelconferences.com.au

Contact Details:
North Lakes Specialist Suites
Ground Floor
7 Endeavour Boulevard
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All Appointments: 3861 5522

Dr McIntosh will be providing an ENT clinic and operating at North Lakes Day Hospital from January 2015

An Update in Paediatric ENT by Dr David McIntosh

Paediatric ENT The evolution of medicine and surgery sees progress in many areas. The field of Paediatric ENT is not immune to such changes, with sub-specialty training in this aspect of ENT on the increase. The suggestion that children are just small adults is far from the truth, and whilst standard ENT approaches in adults may be partly translated to Paediatric ENT, children retain rather unique qualities that set them apart from the rest. One specific aspect when it comes to Paediatric ENT is the realization that we have under-estimated how significant seemingly small problems in childhood project to life long adult problems. To illustrate the case, here are 2 simple examples- mouth breathing and otitis media.

As innocuous as a child that mouth breathes may seem, such children are manifesting significant airway issues with marked loco-regional and systemic effects. To name but a few, children who are moth breathers are more likely to have sleep apnoea, grind their teeth at night, develop aberrations in dental alignment and facial growth, have subclinical pulmonary hypertension, have nocturnal hypertension, have neck problems and headaches, middle ear disease, and concentration and behavioural problems. Studies show alterations in brain function in children with sleep disordered breathing and these consequences are leading to life long morbidity. There are already legal cases overseas of practitioners being sued for failure to manage ENT problems in an appropriate time frame, and such action is best avoided in Australia by taking a pro-active approach to children with upper airway obstruction being managed by an ENT that specializes in comprehensive upper airway management, and this may include utilizing additional resources such as dentists and speech therapists, with surgery alone increasingly recognized as being only part of the solution.

With regards to middle ear disease, we have seen various forms of guidelines advocating the judicious and ultimately lessened use of antibiotics for acute otitis media. Much of this practice came from Scandinavian country practices, and the introduction of guidelines was based less on evidence and more on the reported collective experience of certain practitioners. It has been telling to see that the rate of grommet insertion in these countries, per capita, is the highest in the modern world, reflecting the development of chronic disease at the expense of managing the acute exacerbations. We are also seeing increasing rates of auditory processing disorder (partly reflected by increased testing by audiology clinics such as Attune), with a history of inadequately managed otitis media unfortunately an associated part of the presentation in some children. The studies highlighting that children with otitis media treated conservatively do just as well as those treated with grommets are biased in that the really bad children are always excluded from such studies and have grommets (introducing a selection bias of lesser severity of otitis media in such study groups), and look only at speech acquisition and pure tone audiometry results, at the expense of more comprehensive assessments to identify children with processing difficulties. In fact research out of the University of Queensland in 2010 showed children with even just a mild conductive hearing loss who had speech problems were struggling with even just the slightest of background noise. Again our paradigm of letting them outgrow it may be very seriously flawed.

References available upon request.

About Assoc Prof David McIntosh

David holds subspecialty qualifications in paediatric ENT (the only ENT working north of Brisbane to hold such qualifications). He also holds a PhD and has been a recipient of an NHMRC research grant. David works in a multi-disciplinary manner with dentists and speech therapists to assist children with sleep disordered breathing. He utilises modern surgical approaches to paediatric airway assessment and treatment, including adenoidectomy under visualistion, as opposed to the blind curette technique. He also runs one of the largest education services on ENT for GPs and dentists in all of Australia.

You can join him for free education posts on Facebook: ENT updates for the GP

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AMA

NEW REPORTS SUPPORT AMA CALLS FOR GREATER INVESTMENT IN GENERAL PRACTICE

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA President, A/Prof Brian Owler, said today that the AMA welcomes the latest Bettering the Evaluation and Care of Health (BEACH) reports, which support AMA calls for greater Government investment in general practice.

A/Prof Owler said that the reports, A decade of Australian general practice activity 2004-05 – 2013-14 and Australian General Practice Activity 2013-14, provide further evidence that general practice delivers the best value for money in the Australian health system.

"Significant investment in general practice is crucial to equip the health system to cope with the ageing population and more patients with complex and chronic diseases," A/Prof Owler.

"General practice keeps people healthy and out of hospital. It makes sense for the Government to invest heavily in primary care, and the most cost-effective quality primary care is provided by GPs.

"It is definitely not the time to be introducing disincentives – such as the Government's proposed model of co-payments for GP, pathology, and radiology services – that would deter sick people from visiting their GP."

A/Prof Owler said the reports show that if GP services were performed in other areas of the health system, they would cost both the Government and patients considerably more than general practice.

"GP services in the Emergency Department, for example, would cost between $396 and $599 each, compared to the average cost of a GP visit, which is around $50," A/Prof Owler said.

The BEACH reports highlight that general practice, over the period 2004-05 to 2013-14, has been doing more to keep Australians healthy than ever before, including:

68 million extra problems managed (48 per cent increase), of which 24 million were chronic conditions such as diabetes and depression;

35 million extra GP-patient encounters (36 per cent increase), 17 million of which were with patients aged 65+ (a 67 per cent increase);
10 million extra hours of GP clinical time (43 per cent increase); and
10 million extra procedural treatments (a 66 per cent increase).

The BEACH publications are available at General practice activity in Australia 2013–14 and

A decade of general practice activity 2004–05 to 2013–14.

11 November 2014

CONTACT:

John Flanner
02 6270 5477 / 0419 494 761

Odette Visser
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Follow the AMA President on Twitter: http://twitter.com/amapresident

RDMA
Newsletter
JUNE 2013

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

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

Annual subscription is $100.00. Doctors-in-training and retired doctors are invited to join at no cost. This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and/ or speakers are most welcome.

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Where We Work And Live

Damaged remains of houses in a street in Villers–Bretonneux France May 1918,

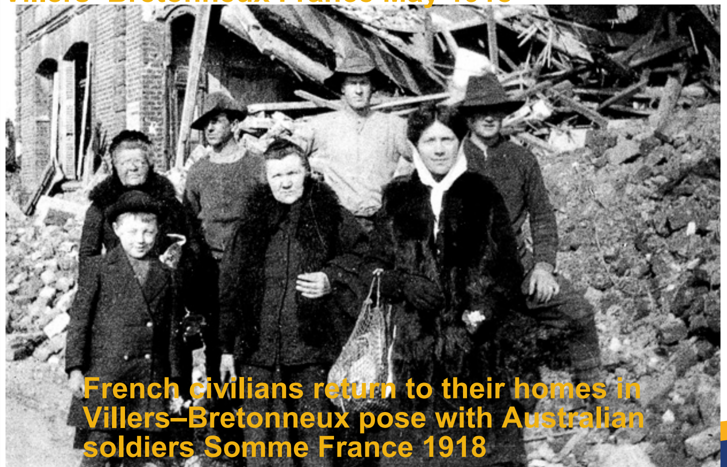
View of the ruined Church of Villers–Bretonneux, France, May 1918.

Remembrance Day 11th November 2014

http://www.ww1westernfront.gov.au/villers-bretonneux/visiting-villers-bretonneux.php

Memorial tablet in remembrance of Australian soldiers who were killed in defence of the town April 1918.

Private Arthur Townsend 46 Battalion Vic preparing vegetables he salvaged from a ruined garden in Villers–Bretonneux France May 1918



French civilians return to their homes in Villers–Bretonneux pose with Australian soldiers Somme France 1918