RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter

OCTOBER 2011

Beachmere

See Beachmere and surrounds featuring in our Historical Pictorial in this edition page 3, 14 and our regular Where We Live And Work segment Page 20

RDMA President's Message ... Dr Wayne Herdy

PRESIDENT'S REPORT.

What a debacle with the Redcliffe GP Superclinics (GPSC)!

The AMA has openly opposed the GPSC plan – as currently proposed. Redcliffe was one of the first, and it was a bad omen that within months of the negotiation stage the local Division removed itself from the planning. GP Superclinics without GP's became the standing operating procedure.

Although Redcliffe was one of the first to see pen put to paper and money change hands, it remains among those that have yet to see its first patient. Not only is it not operational, it has already had to put its hand out for a doubling of the original funding. Despite that, the building is incomplete, there is no staffing and no clinical work going on. And the latest scandal is that the project ran out of money, the State government refused to rescue the plan, and the Commonwealth has had to produce another substantial cheque.

What is wrong with GPSC's?

Firstly, they are based on a flawed perception that GPs are not doing a good job. What better way to get 38,000 GPs off side with a single sentence?

Secondly, they are based on a policy of giving very substantial handouts to private operators to compete on an unfair basis with established businesses. What better way to make all businessmen in Australia re-examine the realities of competitive trading?

But where all GPSC's are failing is their basis in a public sector philosophy. Any GP who owns and runs a big multi-doctor practice could have put a GPSC together in months, if not weeks, and for a fraction of the government's budget. All that had to happen to make GPSC's succeed was to have genuine consultation with established GPs and give to us what they needed to deliver to our patients the services that we know or patients actually need.

GPSC's have a really good intended outcome – to provide a full range of primary care services to those who need it. The ideological outcome of removing overpaid and underperforming GP's from health care was based on false premises, and is doomed to failure.

Back to Redcliffe, the LMA knows that a lot of goodwill and resources have been poured into a project that is failing. Our goal should be to ensure that the work and effort do not go to waste, to put our shoulders behind the limping project and get some positive value for our community.

And the Caboolture GPSC? Watch this space, and let's ensure that history does not repeat itself.

DATE CLAIMERS :

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

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

2011 Dates:

NEXT MEETING

Wednesday October 26

Year End Networking Function

Friday November 25

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NOVEMBER NEWSLETTER 2011

The 17th NOVEMBER 2011 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com or Fax: (07) 5429 8407
Website: http//www.rdma.org.au

INSIDE THIS ISSUE:

Beachmere Business Centre

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT

Dr Richard Kidd

New Mental Health Commission and an Update on Acute Primary Care Clinics

I have just returned from Prague where AMA Queensland held their Annual Conference and I am keen to get back into the major issues our members' are faced with.

The conference was of an extremely high standard and I continue to receive overwhelmingly positive feedback from those members who attended.

The keynote speakers Professor Claire Jackson and Professor Trisha Greenhalgh stimulated much thoughtful questioning and debate. The remainder of our presenters and facilitators also worked hard ensuring that the delegates were stirred with passionate discussion on various issues.

Reflecting on the theme of the conference, innovations in healthcare, a number of key topics were covered including the good, the bad and the ugly of innovations in healthcare, personally controlled electronic health records - a practical understanding and an extremely enlightening presentation on England's national program for IT – the world's most expensive lesson in e-health design and delivery.

I encourage everyone to consider attending the 2012 annual conference set to be held in Madrid!

On the home front I would like to officially congratulate Dr Wayne Herdy who has once again stepped up to the plate to be the President of the Sunshine Coast Local Medical Association.

The State Government has announced the creation of a Mental Health Commission which could really help Queenslanders living with mental illness.

Mental health has been severely underfunded for more than a decade and what funds have been allocated have been fragmented and often poached by other areas of need in the acute health sector. I hope the Commission makes strong recommendations to increase funding for mental health services that will be cohesive and secure.

While there is much potential for the Commission to improve co-ordination of mental health services it must remain genuinely independent and transparent.

AMA Queensland believes the Commission needs to report to a senior minister, such as the Health Minister to ensure that recommendations are properly addressed.

It is time for mental health and drug and alcohol services to be better integrated and coordinated in Queensland around the patient.

As a GP, mental health patients I see often use drugs and alcohol to self medicate. These patients in the past have often fallen between the two services, each service telling the patient that the other problem should be fixed before that service will engage. We must now engage both aspects of the patients needs concurrently.

AMA Queensland as a part of the GP Alliance group has been heavily lobbying against the introduction of Acute Primary Care Clinics in Queensland Hospitals as I mentioned in my last report.

These clinics are being touted as general practice clinics. While they may provide some primary care services they are not cradle to grave continuous care by a family doctor providing the full range of services and support.

We remain concerned that the MBS billing arrangements may not be legal. They have been set up outside of the section 19(2) exemption process and may be breaching business rules under the National Health Care Agreement.

We have called for an immediate moratorium on the roll out of these clinics across the state and for Queensland Health to cease MBS billing at all Acute Primary Care Clinics until these concerns are addressed.

I am also deeply concerned that our members who are Queensland Health employees are being pressured or influenced to procure MBS provider numbers and have services bulk billed through these provider numbers. I believe that some of our members are going to be put in harm's way.

We will be producing a fact sheet to help our members appreciate the risks and obligations involved in claiming Medicare item numbers.

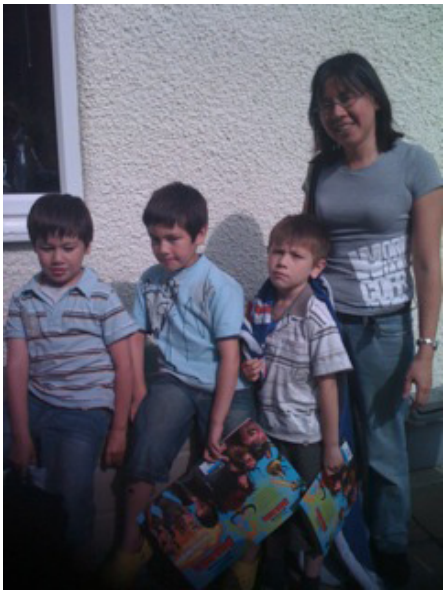
Richard Kidd

AMAQ President

DR LAUREL YOUNG, RHEUMATOLOGIST JOINS REDCLIFFE AND NORTHSIDE RHEUMATOLOGY

Dr Laurel Young will be returning to the Peninsula in January 2012 after an extended time in the UK.

Laurel graduated from Sandgate High School and completed her undergraduate medical studies at UQ. After an intern year in Redcliffe Hospital, she finished her basic physician training at RBWH and rheumatology studies in Sydney.



She moved to the UK in 2000 and worked at the Royal Berkshire Hospital, Reading, St Thomas & Guys Hospitals, London.

She returns to Queensland with her three boys and husband Greg. She will join

me in private practice on the Peninsula from late January 2012 . We look forward to improving access to rheumatology services in the area.

Dr Claire Barrett

Diabetes Care Clinic

QML Pathology has launched one of Australia's first dedicated Diabetes Care Clinics in Queensland.

Run by Credentialled Diabetes Educators, the Diabetes Care Clinic is dedicated to helping people with diabetes improve their health and lifestyle. The Clinic achieves this by working closely with patients' GPs to develop management plans and by providing education sessions for groups and individuals.

The clinic is 100% bulk billed for Medicare eligible patients, and patients living with type 1 and type 2 diabetes can obtain a referral to the Clinic by scheduling an appointment with their GP.

Once referred, the client will be contacted by the Diabetes Care Clinic team to arrange a clinic appointment during which the Educator will develop a comprehensive management plan, tailored to each individual's requirements.

Each patient's GP will continue to oversee their diabetes management plan, with QML Pathology providing reports informing the GP of their patient's progress.

The Clinic educates patients to better understand their condition, monitor their glucose to self manage, understand the importance of healthy eating and physical activities, as well as using insulin safely and effectively. The Clinic can also organise additional appointments with allied health professionals, such as dietitians, exercise physiologists and podiatrists.

To find out more about the Clinic including practice incentives for diabetes management, please contact Margaret MacPherson, Medical Liaison Officer on (07) 3049 4444.

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

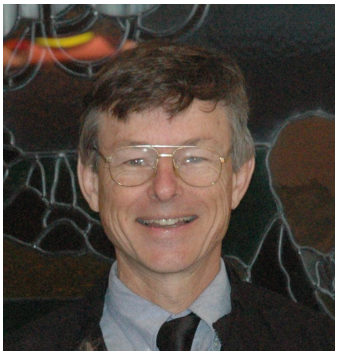
- Run by Credentialled Diabetes Educators
- Appointments at various collection centre locations
- Group education for type 2 patients
- Claimable practice incentives for diabetes management
- Bulk billed service for type 1 and type 2 with EPC referrals.

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

QML Pathology.
Specialists in Private Pathology since the 1920s

New Executive Team

Meeting held on 6th October 2011



Peter Stevenson, Treasurer

Wayne Herdy President

Kimberley Bondeson Vice President

Ken Fry Secretary

The Redcliffe & District Local Medical AssociationRDMA Meeting held on the 21/09/11 was presided over by Dr Wayne Herdy, RDMA's President.

The Meeting Sponsor was Novartis Pharmaceuticals whose representative Damian Anderson and Andrew Butler introduced the night's presenter Dr Andrew Smith.

The topic of the night was Diseases of the Eye and The Diabetic Patient.

Left to right: Medical Students: Vinesh Appaduri, An Yoong – Kyo and Natalie Ong.

Ray Collins, Gordon Chan, Ham Ong, Andrew Smith

Presenter: Dr Andrew Smith

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: Wednesday 26th October 2011

Time: 7 for 7.30pm

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

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

Agenda:

7.00pm	Arrival and Registration
7.30pm	Be seated - Entrée served Welcome by Dr Wayne Herdy - President RDMA Inc.
7.35pm	Sponsor: Moreton Eye Group
7.40pm	Speaker: Dr Mark Donaldson Topic: Flashes and Floaters/Tears and Detachments
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: Margaret.MacPherson@qml.com.au
t: 3049 4429 by Tuesday 18th October

QML Pathology.

SNAPSHOT FROM THE PAST - Rapid Changes To Health

REDAMA Newsletter from October 1989 Issue 7, page 5

RAPID CHANGES TO HEALTH

The following is a precis of a talk was delivered to the September meeting of the Redcliffe and Districts Local Medical Association by Dr Bruce Flegg.

Dr Flegg is a member of the LMA and the endorsed Liberal Candidate for the Federal seat of Petrie.

Today, we are witnessing the most rapid change in health policy since the introduction of Medicare.

These changes are being introduced by a Government that could rightly be described as hostile to the medical profession.

The two main areas of policy I would like to address are Medicare and Two Tiered Fee Structures.

Bearing in mind that the Liberal health policy is not yet released, most key details have been foreshadowed.

You will be aware that the two-tiered system has been passed by the Senate and begins on December 1, 1989.

The Liberals opposed it because

- It is discriminatory against the definition of general practitioner;
- It is discriminatory against women;
- Power is too concentrated in the hands of the closed shop Royal Australian College of General Practitioners;
- The intent of the Senate Committee of a totally separate stream outside RACGP has not been embodied in the l'slation;
- The Vocational Register Committee may be dominated by RACGP members to the exclusion of other groups.

What will the Liberals do when the system is up and running when we come into Government?

Dr Warwick Carter says the AMA is giving its guarded support as the scheme is a fait accomplis and that we will be working with the RACGP to overcome the anomalies.

Medicare was launched in 1984 by the present government with a promise to deliver a health care system which would be accessible to all, according to need, and funded by all, according to income.

But private health insurance has become a luxury most patients simply cannot afford.

Here, in Queensland for instance, only 32 per cent of the population has private health insurance.

It's well documented that these circumstances have resulted in long waiting lists in an overcrowded public hospital system, while private hospitals have only limited opportunity to take up the slack.

Contrary to the present Medicare arrangement, which allows this great imbalance, the Health Care system under a Liberal Government will balance the scales with a better mix between public and private hospitals.

While the Government has not made more money accessible to the hospitals, and has not increased its 7.8% GDP since it took office, it has managed to make certain the Medicare scheme is funded by all, by firstly introducing the health tax euphemistically called the Medicare Levy and then increasing it to 1.25% of income tax in 1986 and removing the ceiling amount.

Despite this fact, at present the 1.25% Medicare levy only funds one sixth of health care costs. One third comes from individuals, a further one sixth from private insurance and the one third balance from general taxation.

It is general taxation which pays for the shortfall of money.

This creates a situation where 46% of the population is forced to pay three times for health care, through their taxes, the Medicare levy and private health insurance premiums.

A Liberal Government will abolish this cumbersome arrangement, in a health care system which will allow only one payment for Health Care.

All Australians will either be in a private insurance fund of their own choice or in Medicare.

The Liberal Party believes Medicare has failed in its objectives of fair and equal health cover for all Australians.

We believe every Australian should be given an equal opportunity to take care of their own health insurance, and be independent just as they manage their own family budgets for food and choose their own doctor.

To achieve this, the Liberal Party will retain Medicare but improve it with emphasis on helping those Australians who simply cannot afford to look after their own health cover, in particular the aged and disadvantaged.

As part of this system, all Australians will be encouraged to take out, or maintain, private health insurance.

The Medicare levy will be abolished and taxation rebates re-introduced to assist with health insurance premiums, putting quality health care within everyone's reach.

A Liberal Party government would not take over payment for everyone, regardless of wealth, as the present Labor arrangement does.

The unworkable, impersonal Medicare scheme will be replaced by a more personal, workable and thus,more efficient health care package which gives all Australians equal chance for comprehensive cover.

The Liberal Party has no problem in principle with an attempt to improve and upgrade the status of general practice is Australia - indeed, the sky is the limit.

The Liberal Party questions whether a vocational register will be conducted in a way that all practitioners have an equal chance of gaining entry and maintaining their position on the register.

The content-based consultation items, which can only be used by general practitioners on the vocational register, are also questionable since those of our colleagues who are not on the registered will not receive the same amounts for consultations and their patients will not receive their rebates.

This system disadvantages both the doctor and the patient and will unsettle the doctor-patient relationship further, since it puts the doctor's reputation in doubt in the mind of patients and potential patients.

The Liberal Party believes there are other ways to update our current system, and at the same time, improve it for us, the GPs and for our patients.

But such a plan can only be worked out through consultation and discussion between all parties concerned, during all stages of the making of the proposal.

One possible solution is to incorporate vocational training for potential GPs at an undergraduate level.

While many aspects of general practice cannot be taught in academic training, such as talking to and handling patients face to face, under graduates could at least have experience of these types of situations before graduation.

If such vocational experience were incorporated into training, it would eliminate the need for a two tier system, since all GPs would be equal on graduation and all could reap the benefits of higher rebates for their patients.

The other issue for mention is the Disability Services Act.

While the intentions of the Act may be commendable, since it allows for the intellectually and physically handicapped a gateway for a more independent life, its application to all intellectually handicapped will pose difficulties.

Many of the people, at whom the scheme is aimed, have too severe a handicap to gain any benefit from its proposed structure.

As money is gradually taken from sheltered workshop type programmes, those more dependent people will be disadvantaged, rather than helped, by the scheme.

Another group in the health field who are suffering financially at the hands of the government are the pharmacists.

The government's proposals will mean ruin for many pharmacies since they will find it difficult to make a profit.

It is the Government's stated position to force a reduction in pharmacy numbers by economic hardship.

The Liberal Party believes a total re-organisation of the health system is needed to overcome the present problems.

The policy is to retain Medicare but by the time it has undergone the surgery I have described, the patient will be hardly recognisable.

The nation's health, and its health care, is much too critical be guided merely by economic needs.

Economic constraints will always exist in health care. We will only get top quality health care by allowing individuals to decide their spending priorities, not Governments deciding for them.

AMAQ & FEDERAL COUNCILLOR REPORT

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

A BIG ACT IN TOWN

When there's a big act in town, it's hard to attract an audience.

The big acts in the little town of Canberra are carbon tax and boat people. Close on the back stage are all the issues of the delicate balance of power, the looming prospects of early election (which the PM will not call with the current dismal polls) or by-election (if either side wants to press the salacious issues that could have a sitting member have to step aside). Health politics is not attracting much attention at all.

Despite all that, the AMA keeps plugging on with our bread-and butter issues.

The most important one, to my mind, is the proposed changes to the mental health incentive payments. Why is this so important? Firstly, it creates a bad precedent of reducing a well-established payment once the providers and consumers have become accustomed to the service that was being funded.

Secondly, the money that is being taken away from GP's will be given to others. It would be bad enough if money previously dedicated to doctors were only going to be given away to non-doctor health practitioners, but in this case a lot of the budget is going to be diverted to corporations that have only indirect effects on health outcomes.

Thirdly, GP's who provided the mental health services have demonstrated that they can, as Australian doctors inevitably do, provide a valuable service to our patients at remarkably low cost and with substantial savings by preventing ongoing losses. We cannot let this proposal go unchallenged. There are too many large principles involved.

One of the moths that keep fluttering out of the wardrobe is the question of Big Pharma and how drug companies keep bribing doctors with pens and free lunches. There is a renewed push to have openness and accountability of the small and larger pecuniary incentives for prescribers and users of expensive medical appliances. This is always fascinating fodder for the public press, and one which the journalists habitually resort to in doctor-bashing season.

It is especially timely in Queensland this month, where the pecuniary interest register of politicians has drawn a lot of public notice, the government openly challenging Campbell Newman's past disclosures.

In the renewed context of a long-standing debate, the AMA is being forced to make an open statement about incentives offered to doctors.

We doctors know how little we receive by way of bribes, so it will only be a tiny minority who has anything to worry about. I suspect that, while the battler might grumble that GP's are getting a daily sandwich, most who live in the world of real business will be surprised at just how small are the gifts that lubricate the relationship between doctors and drug companies.

What is inevitable is that we must agree with full and open disclosure. Anything less will leave an impression that doctors and pharmaceutical companies have something to hide.

It would be nice to get the whole issue out in the open and have the books closed on suspicion and innuendo, but I guess that even with every free scribble pad revealed on the Internet, the debate will keep re-surfacing forever.

A pity that the same has not happened in the past with CEO salaries, and I wonder what will be the final outcome of the current Occupy Wall Street campaigns in the USA and Europe.

Wayne Herdy

REDAMA Report
Official publication of the Redcliffe and Districts Local Medical Association
Issue No 7
October, 1989
Free to the Medical Profession

NOSTALGIC MEMORIES

Nostalgic memories of great moments in the history of Redcliffe and Districts LMA came drifting back when retiring hospital superintendent, Reg Neilsen was officially farewelled at the September meeting.

After 22 years as superintendent at Redcliffe, Reg has hung up his administrator's shingle and will head into a well-earned retirement knowing his peers acknowledge and salute his contributions to medicine in a long and distinguished career.

A foundation member of the Redcliffe LMA, Reg was the focus of attention as firstly Dr Peter Marendy and then Dr Ralph Smallhorn and Dr Bernie Chan toasted their colleague and recounted some of his less medical exploits as superintendent.

According to Peter, one of Reg's greatest attributes was his diplomacy.

"There was never a conflict with him because whenever there was a problem, he was always away at a conference or a training session," Peter reckoned.

On a more serious note, he said that in those days, superintendents were not well paid, there was no superannuation and you learned your medicine the hard way.

HARD LIFE

"Reg found life hard but he was professional, capable and dedicated," Peter said.

"In those days, Redcliffe had a population of about 13,000 and people were gravitating here like flies to the honey pot.

"Graham Hyslop even slept here.

"We carried out our first cataract operation in 1967 but there have been a lot of (LMA) meetings since then and we have all come to know Reg much better."

Peter declared that Reg had the respect of the medical profession, the nursing profession "and all of your colleagues."

Ralph urged the medical fraternity to acknowledge the contributions of Reg's wife, Gwen over the years.

"There is very little this doctor can't do but he has been able to count on the support of his wife at all times," said Ralph.

In his reply, Reg recalled how Redcliffe Hospital had always been a very busy place that had only two resident doctors when he first arrive

"There were times when I could have strangled a few people but the chairman was never available," he confided.

He admitted he had been overseas "a few times" but it was always work, he declared.

On behalf of the LMA, Peter Marendy presented Reg with two bottles of a "very select" port which he can sip while he relaxes in the rocking chair presented by his admirers at the hospital.


REDAMA Report
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Issue No 7
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Free to the Medical Profession

Call to release inquiry details

Redcliffe and Districts LMA is calling on the Health Department to urgently release details of the findings of a top level inquiry into the critical shortage of beds at the Redcliffe Hospital.

The inquiry was carried out more than six months ago and the LMA has so far been unable to find out what conclusions and recommendations were reached.

A deputation comprising LMA president, Dr Kerry Garske, secretary Dr Helen Mahoney and treasurer, Dr Frank Cunningham, met representatives of the Hospital Board on Wednesday, October 11, to discuss the crisis.

The meeting agreed there was a need for pressure on the State Government for increased accommodation at the hospital.

But the need for an all-out campaign might be avoided if the Government, through the Health Department, revealed findings of its inquiry and any plans that might have been formulated, according to Dr Garske.

The deputation expressed growing concern in the medical fraternity at the critical shortage of beds at the Redcliffe Hospital and the increasing incidence of patients being by-passed to Royal Brisbane Hospital.

But Dr Garske says investigations suggest more than 200 patients might have been taken straight to Brisbane, because there were no beds at Redcliffe, over the past two or three years."

The LMA believes the by-pass system is being invoked at least once a week and sometimes more, and it has been this bad for two or three years.

• Continued Page 8

Two "old mates" together as Peter Marendy presents the LMA's retirement gift to Reg Neilsen (right) at the September meeting. See story Page 3.

AMA NEEDS HIGHER PROFILE

The need for the AMA (Queensland) to develop a higher profile with its own members as well as the general public was one of the main points raised at a special meeting of members called in Brisbane on October 11.

Reporting on the meeting which was an open forum chaired by Dr Warwick Carter, Redcliffe L.M.A. vice-president Dr Bob Brown said about 40 doctors attended, approximately half of them specialists.

The meeting was called by the AMA to investigate ways of expanding membership and sought input from doctors on paths the AMA should be taking to improve communication with members and the public.

Dr Brown said that the meeting felt greater emphasis should be placed on attracting medical students and young graduates into the AMA.

"It was also felt that women doctors working part-time in general practice should also be encouraged to join," he said.

"A subsequent discussion on charges revealed that some groups may be encouraged to join if they had to pay less than the normal fee.

"The women doctors working part time and young doctors in training were two of the groups mentioned in this category," Dr Brown said.

Members of the AMA are to be canvassed to make personal approaches to non-members of the Association to ascertain why they do not belong, and to encourage them to join.

"It was also suggested that the AMA maintains too low a profile and a higher profile should be adopted," Dr Brown said.

"This included better communication between the AMA and its members and the public."

Speaking after the meeting, Dr Brown said he had the feeling one of the major problems the AMA had to face was the lack of support from general practitioners.

"This lack of support could well be caused by the practitioners having the view that the AMA does not fully understood their problems such as community attitudes and the growth of bulk billing practices," he said.

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #86

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

Pictographs "Show Me The Way!"

One of the first things that medical students learn is how to take a good history. That chest pain that feels like it's burning every time you bend over is probably less serious than a crushing pain radiating into the left arm on exertion.

And the sudden onset of the worst headache ever whilst straining at stool is likely to be much more serious than a headache that comes on after a long day consulting.

History-taking relies on good communication skills, and it also helps if both parties can speak the same language.

But the nuances of accents can still make it very difficult to communicate even when both parties are speaking English.

Unfortunately, even trying to raise the topic of accents and understand-ability carries the risk of being accused of racism.

Only last week an English-speaking full fee-paying Canadian medical student confided in me how much trouble he had understanding the Australian accent. I quickly pointed out to him that "we" didn't actually have an accent at all and that it was only "him" that was a little hard to understand.

At the moment my all-time most difficult to understand doctor comes from the northern part of a small island where cricket is a major sport. No, it isn't the Tamil speaking Doctor Muttiah Muralitharan from Sri Jayawardenapura-Kotte, it's a Celt by the name of Doctor Angus McSporran.

As an IMG Doctor McSporran must have been spared the IELT English language test or perhaps he sent an English-speaking decoy in his place.

Nurses routinely follow him on his ward round to translate his instructions from his broad Scottish tongue into something that the patients can understand.

A few years back he hit the jackpot when he was sent off to do the Dementia-screening on an elderly relative of mine. My partner's centenarian grandmother had unfortunately had a fall and broken her hip. Granny was mentally perfect and the evidence for this was that she never forgot my birthday and always remembered to send me a present.

But protocols demanded that she must have an MMSE and unfortunately she was stuck on Question 14 which was worth 5 points.

Doctor McSporran asked her to spell the word "WADDLE" backwards. Granny rightfully said, "E-L-D-D-A-W". He said, "No spell WADDLE backwards!" Granny repeated, "E-L-D-D-A-W".

Frustration was building on both sides when it suddenly dawned on my partner that Doctor McSporran was trying to say the word, "WORLD!" Granny then passed the test once she was given the word in English, rather than Scottish.

Car companies produce vehicles for the whole multi-lingual world. Whilst it is possible to print manuals in many different languages, the controls and dashboard need to be labelled universally.

For decades automotive engineers have utilized pictographs to communicate ideas, rather than words.

Historically, pictures carved into rocks by cave men and hieroglyphics on the walls of an Egyptian tomb have allowed humans to communicate without the spoken word Road signs visually tell us what to do, avoiding the ambiguity of verbal language.

So with all of this multi-lingual imagery most of us still over-look simple bits of information that are staring at us all the while. Take the fuel gauge for example. All of those arguments about which side the filler cap was on could have been won if you simply took a look at the hose on the bowser in the pictograph on the gauge.

It's on the same side as the filler cap, "Doh". And looking at the pictograph is still far easier than asking your passenger (Doctor McSporran) for advice.

Clive Fraser

Interesting Tidbits NATTY MOMENTS:

Universal Law

Law of Mechanical Repair - After your hands become coated with grease, your nose will begin to itch and you'll have to pee.

Law of Gravity - Any tool, nut, bolt, screw, when dropped, will roll to the least accessible corner.

Law of Probability -The probability of being watched is directly proportional to the stupidity of your act.

Law of Random Numbers - If you dial a wrong number, you never get a busy signal and someone always answers.

Law of the Alibi - If you tell the boss you were late for work because you had a flat tyre, the very next morning you will have a flat tyre.

Variation Law - If you change traffic lanes, the one you were in will always move faster than the one you are in now (works every time).

Law of the Bath - When the body is fully immersed in water, the telephone rings.

Law of Close Encounters -The probability of meeting someone you know increases dramatically when you are with someone you don't want to be seen with.

Law of the Result - When you try to prove to someone that a machine won't work, it will.

Law of Biomechanics - The severity of the itch is inversely proportional to the reach.

Law of the Theater and Hockey Arena - At any event, the people whose seats are furthest from the aisle, always arrive last. They are the ones who will leave their seats several times to go for food, beer, or the toilet and who leave early before the end of the performance or the game is over. The folks in the aisle seats come early, never move once, have long gangly legs or big bellies, and stay to the bitter end of the performance. The aisle people also are very surly folk.

The Coffee Law - As soon as you sit down to a cup of hot coffee, your boss will ask you to do something which will last until the coffee is cold.

Murphy's Law of Lockers - If there are only two people in a locker room, they will have adjacent lockers.

Law of Physical Surfaces - The chances of an open-faced jelly sandwich landing face down on a floor, are directly correlated to the newness and cost of the carpet or rug.

Law of Logical Argument - Anything is possible if you don't know what you are talking about.

Brown's Law of Physical Appearance - If the clothes fit, they're ugly.

Oliver's Law of Public Speaking - A closed mouth gathers no feet.

Wilson's Law of Commercial Marketing Strategy - As soon as you find a product that you really like, they will stop making it.

Doctors' Law - If you don't feel well, make an appointment to go to the doctor, by the time you get there you'll feel better. But don't make an appointment, and you'll stay sick.

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.

THE "EGG TIMER TEST"

A woman is born with approximately 1 million eggs and over her reproductive life this number will decline as they are lost through natural attrition (apoptosis) as well as ovulation. The rate at which eggs are lost through natural apoptosis varies between individual women and it is estimated that at least 10 per cent of the population will experience accelerated loss of eggs. A new test has recently become available which is able to test for a hormone that correlates with the number of eggs left in the ovaries. This hormone is called the Anti-Müllerian Hormone (AMH) and is produced by immature eggS producing cells in the ovaries. Hence as a woman runs out of eggs the number of immature eggs producing cells decreases and as a result the level of AMH decreases.

A low AMH level (<14 pmol/l) indicates a low egg reserve and high levels of AMH can be indicative of other ovarian problems. This test has recently been introduced to IVF Sunshine Coast and IVF Caboolture as part of routine screening bloods for new patients. AMH testing may also give advanced warning of a premature decline in fertility and can be done at any time in a woman's monthly cycle.

Who is this test suitable for?
a) Women considering IVF and other fertility treatments as AMH levels are seen as **a good predictor of IVF success**

b) Women under the age of 38 who are considering delaying pregnancy for social/personal reason

c) Women who have had chemotherapy or ovarian surgery and want to find out what effect it has had on their future fertility

See the case studies below:

Patient 1: a 29 year old woman presents to her specialist to have gynecological treatment unrelated to fertility. AMH testing is done as part of routine screening and an AMH of 2 is found. The patient has an IVF cycle to freeze embryos for later use, however only 1 egg is collected with no embryos suitable for freezing.

Patient 2: a 33 year old woman undergoing an IVF cycle has an AMH test as part of her routine blood screens prior to commencing her treatment. An AMH of 24 is found and her hormone dose is adjusted accordingly. A total of 13 eggs are collected, with 1 embryo transferred, 7 frozen, and a pregnancy resulting.

IVF Sunshine Coast and IVF Caboolture

Beachmere's Historical Article

Beachmere is a picturesque little town which is on the west shore of Deception Bay, near the mouth of Caboolture River, south of Bribie Island Passage.

It was founded in 1906 by just four families. The name means "Beach On A Marshy Area" with boat jetties, back access to rivers, the bay and the open sea.

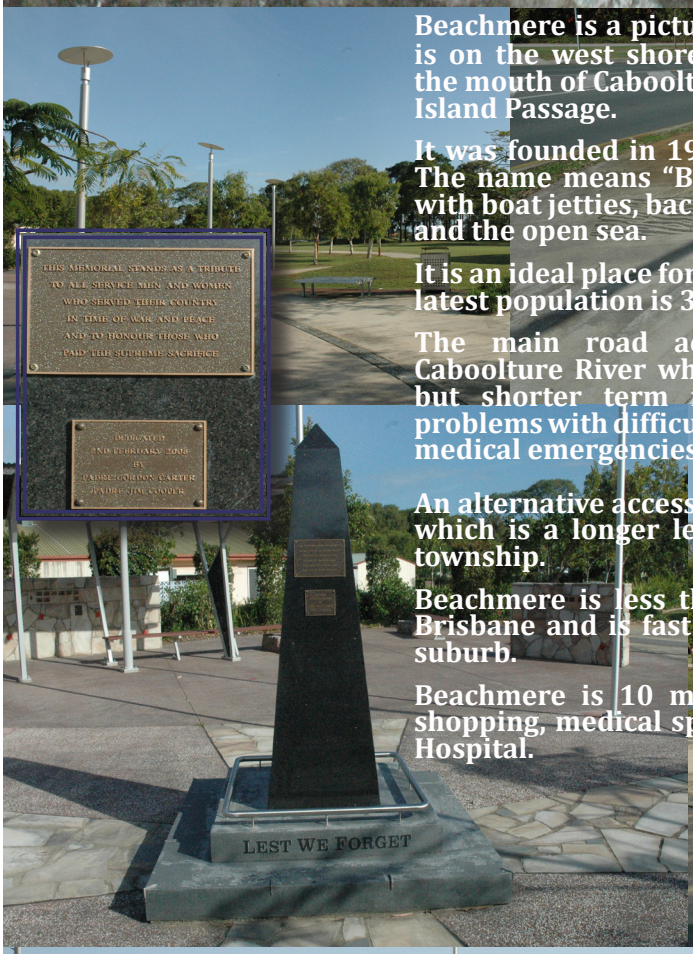
It is an ideal place for boating and fishing. The latest population is 3516 in the 2006 census.

The main road access runs beside the Caboolture River which is prone to frequent but shorter term flooding. This creates problems with difficult logistical access during medical emergencies.

An alternative access is via Bribie Island Road which is a longer less direct journey to the township.

Beachmere is less than 1 hour's drive from Brisbane and is fast becoming a commuters' suburb.

Beachmere is 10 minutes from Caboolture, shopping, medical specialists and Caboolture Hospital.



Lillian van Litsenburg MP Member for Redcliffe

P.O. Box 936 P: 3284 2667

Redcliffe Q 4020 F: 3283 1073

redcliffe@parliament.qld.gov.au

13th October 2011

Local Health and Hospital Networks set to commence

With the Local Health and Hospital Networks becoming a reality on 1 July 2012 we need to have a conversation about how this will affect Redcliffe and the Moreton Bay Region.

The Members of the Local Network will be appointed in the next few months and they will be responsible for the operational management of their local hospital and health services in their region.

That is a huge responsibility so the people needed will have governance skills, understanding of clinical services, budgeting and human resources among others.

Redcliffe Hospital Professionals have a history of thinking out of the box and developing a raft of ground breaking services that have won awards and improved the efficiency of many services in the hospital.

These have included the use of Practice Nurses in the Emergency Department, the development of the new patient flow system in the Emergency Department, the award winning Specialist Outpatient systems and the training programs for paramedics.

These are only a few of the improvements that have been achieved because of the quality of health professionals at Redcliffe Hospital collaborating to ensure patients have the most efficient health service they can achieve.

No amount of money can achieve this level of commitment to best practice in service provision.

With the creation of the Local Networks there will be more opportunities to think out of the square and develop specific services targeted to the needs of our local community instead of inheriting a service which is rolled out across the state but which could be changed to be more effective for our local community.

This is a huge challenge that all of Queensland is about to face. I would love to hear your thoughts, ideas and suggestions about the things you see that need to be changed. You can contact email me at redcliffe@parliament.qld.gov.au or give me a call on 3284 2667.

BEACHMERE MEDICAL CENTRE FIRST ANNIVERSARY

Beachmere Medical Centre has been open since November 2010 and now has three full-time General Practitioners, two Practice Nurses and opening hours on all seven days of the week. We are conveniently located in Beachmere Shopping Village off Beachmere Road and James Road, near to two Pharmacies and other local amenities.

Our opening hours stretch from 7 am until 7 pm Monday through Friday, and 8.30 am until 1 pm on Saturdays & Sundays. Appointments and enquiries can be made by phoning (07) 54962499, and we shall shortly have our new website up and running at http://www.beachmeremedicals.com.au full of important information, news, and with the availability of General Practitioners' appointments displayed.

The Centre is currently taking part in the Royal Australian College of General Practitioners' Accreditation Program which shows our commitment to meeting standards of excellence. Dr Steve Kane-ToddHall is the Clinical Director and works closely with our two female General Practitioners; Drs Claire Ferreira and Devika Jayawardena, to ensure an ongoing commitment to excellent, patient-centred, individualised care that is evidence-based and seeks to be friendly, thorough and meet your needs on an ongoing basis. Home visits are available, though on an individualised basis to established patients of the Centre and at the General Practitioner's discretion.

Most importantly, our patients benefit from bulk-billing for almost all services (irrespective of whether they hold any concession cards), the ability to book an appointment and not just sit and wait for hours on end, and the ability also to book to see their preferred General Practitioner or the Nurse. As our patient list grows, we fully intend to expand the number of staff and the opening hours of the Centre.

Patients have the option of paying for certain services if they want to, which is a value-added private service that remains optional - such as for consultations lasting more than 10 minutes by patient choice, for consultations arranged at times not usual for the requested General Practitioner, and for certain letters and other items of paperwork.

Medicare occasionally changes the rebates that they are willing to pay for some items of service, never intending that rebate to equal the value of that service, and notice would always be given if any service will thus attract a gap fee. To make matters easier, the Centre is obtaining a card machine that allows for payment of any gap fee with instantaneous rebate of the Medicare fee. At the moment, such charges are truly exceptional, and for most patients most of the time the services that we offer are fully bulk-billed.

Of course, we provide all usual services; consultations, mental health plans to access Psychology Services, Care Plans with team care arrangements to access Allied Health Services, Medication Reviews, Minor Surgery Procedures, Childhood and Adult Immunisations and Health Checks, Health Assessments and Assistance (for those who are 75 and over, 45 to 49, of Aboriginal or Torres Strait Islander origin, to name a few), and Contraceptive Services including Implanon insertion & removal. We also enjoy great relationships with local Allied Health Care, Psychology, Dental and Specialist Colleagues, and we hope that this is of great and continuing benefit to our patients.

Looking forward to serving you and improving your health- Beachmere Medical Centre.

Dr Steve Kane-ToddHall

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOC
VICE PRESIDENT REPORT
Kimberley Bondeson

EHealth – Personal Electronic Health Record

"The Devil is in the Detail" – this was the name of an extensive research article written by Professor Trisha Greenhalgh, the Director or the Healthcare Innovation and Policy Unit at Barts and the London School of medicine and Dentistry, London, UK.

Trisha gave a dynamic talk on EHealth (personal electronic health record) at the recent AMAQ conference in Prague. She opened her talk by confirming that morning that England's Pound Sterling 13 billion National Programme for IT had been scrapped, considered useless. The program had run from 2003 to 2010 and cost the British Government 13 billion pounds. Sound familiar? It should. It seems like Australia is following the UK's experience.

Trisha had originally been employed by the British Government to report on their program and to give some recommendations, which she did in her extensive paper. Of her 10 recommendations, only 2 were taken up, and these were passed onto another group, who glossed over them – and so it goes on.

Trish gave an excellent summary of other countries experience with Personal Electronic Health Records. It seems that once a population gets above 5 million, it does not work. This was seen in Denmark, and Singapore, to name a few countries.

The UK experience was quite unique, in that the UK approach to EHealth was divided into Scotland, Wales, Ireland and the UK. Each took a different slant on what the Personal electronic Health Record was and how to go about it.

The Welsh experience (population 3 million) designed an EHealth Record, which included every bit of information and data that could possibly be put into it. It is fairly useless to doctors, however, as it is controlled by the patients themselves, and large bits of the data and info is blocked off, as the patients choose who they want to see it and what they want that particular doctor to see.

Scotland has been much more successful, their EHealth record contains a list of allergies and medications only.

Ireland is using Scotland's format.

UK – dumped it completely.

New Zealand, Denmark and Singapore – once the population reaches above 5 million, it appears to be unmanageable.

Are we learning from other countries mistakes? It doesn't seem like it. It would appear that Australia is sadly, in for a very expensive lesson.

Kimberley Bondeson
Vice President

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Website : http://www.ama.com.au/

MEDICARE PATIENT REBATES REMAIN INADEQUATE

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The Government has again failed to increase Medicare Benefits Schedule (MBS) patient rebates sufficiently to reflect the real cost of providing high quality medical care to the Australian community.

From 1 November, the MBS patient rebate for a standard GP consultation will increase by just 70 cents to $35.60.

AMA President, Dr Steve Hambleton, said today that proper and realistic indexation of Medicare patient rebates is urgently needed.

"Inadequate or no MBS indexation, along with threatened cuts to some MBS fees (Better Access mental health services) and the withdrawal of MBS funding for other services (for example, joint injections) mean that the Government is simply shifting costs to patients.

"Families will have to pay more every time they visit the doctor.

"This sends a bad signal to general practice at a time when the Government is attempting to promote positive messages about its primary health reform agenda.

"It comes on top of the Budget cuts to GP mental health services and the mismanaged GP Super Clinics Program."

The overall Medicare fee increase of just two per cent is inadequate when compared with the Labour Price Index of 3.94 per cent and CPI of 3.18 per cent.

The Labour Price Index (3.94 per cent) and CPI (3.18 per cent) have been calculated for the AMA by Kilham Consulting based on actual data for the three quarters, December 2010 to June 2011, and a forecast for the September 2011 quarter.

The AMA List of Medical Services and Fees reflects these more realistic indices. As a result, AMA recommended fees this year have been indexed on average by 3.2 per cent.

The new AMA recommended fee for a standard GP consultation will be $69, up $3 from $66 in 2010.

The AMA is also concerned that all Nurse Practitioner MBS items have been indexed, while MBS items for Other Medical Practitioners (OMPs), usually non-Vocationally Registered GPs (non-VRs), have not.

This means that the MBS fee for a 30-minute consultation with a Nurse Practitioner ($39) is higher than the MBS fee for the same consultation with a qualified medical practitioner ($38).

Dr Hambleton said that the difference between the MBS and the AMA fees is the result of a long history of MBS indexation lagging well behind the cost of delivering high quality patient care. The time that doctors spend managing patient care after the patient has left the surgery is not accounted for in the MBS fees.

"This year's inadequate MBS indexation has widened the gap.

"Practice costs including employing practice staff, and operating expenses such as rent, electricity, computers, accreditation, and professional insurance must all be met from the single fee charged by the doctor."

The AMA List of Medical Services and Fees provides guidance to AMA members when setting their fees, based on their own practice cost experience.

The 2011 MBS indexation is two per cent. However, pathology, diagnostic imaging, and other medical practitioner fees have not been indexed. Therefore, the total indexation is actually much lower.

13 October 2011

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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

1. Dr. _____ _____
(First Name) *(Surname)*

2. Dr. _____ _____
(First Name) *(Surname)*

1. *EMAIL ADDRESS:* _____@_____

2. *EMAIL ADDRESS:* _____@_____

Practice Address: _____ Post Code: _____

Phone: _____ Fax: _____

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

METHODS OF PAYMENT:

1. 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

Beachmere