RDMA
RDMA & NLMA's Joint Newsletter

Newsletter
OCTOBER 2014

AMAQ Conference Capetown, Africa 09/2014

See Where We Work & Live AMAQ Capetown Conference Pictorial on pages 1, 8 and 20 with Bob, Graham and Kimberley.

President's Report Dr ROBERT (BOB) BROWN

This week is my first fill week back at home after returning from the AMAQ Conference in Cape Town. For those who have not attended these conferences I have to say that, not only are they excellent multidisciplinary meetings, but give an excellent insight into the health and welfare of the host countries.

I am amazed at the efforts of the South Africans to help their own nation cope with the modernisation of their country, the influx of so many "illegals" and the management of potential epidemics of severe communicable and parasitic diseases.

A wonderful place to visit and I encourage the reader to think of visiting their exciting country.

I have attended three night time meetings this week. On Tuesday night, the Northside Local Medical Association (www.northsidelma.com), on Wednesday a Committee Meeting of the Medical Benevolent Association of Queensland (www.mbaq.org.au); and last night, the Past Presidents Dinner of the AMAQ (www.amaq.com.au).

I would like to broaden the knowledge and support for MBAQ and I would like to talk a little bit about the organisation. It was formed to be able to offer financial aid to approved cases of hardship of members and families of Queensland Medical Practitioners.

To achieve this, we rely on the generosity of the public and especially the broader medical community to support the Association in its work. We will accept any help gratefully, whether it be one off or continuing contributions or help through personal estates.

The MBAQ has been in existence since 1967. The first President of the AMAQ was Dr Evan Thomson (later Sir Evan Thomson). I took over the chair in 2005 when Professor Tess Cramond relinquished it after many years of exemplary work.

We have a hard working committee of medical and non medical members and we are supported by a secretariat from the AMAQ.

Please visit our website for more information and help to support members of the profession who are struggling with personal, hardship and financial problems. I very much appreciate the opportunity of presenting the MBAQ to readers of this magazine.

Robert (Bob) Brown
NLMA President

Dr Kimberley Bondeson President' Report

The AMAQ conference in Capetown was amazing, but the highlight of the trip for me personally was seeing the elephants swimming and playing in Botswana at the Chobe National Park.

South Africa is a beautiful country, and we were made very welcome by the South African people.

The official unemployment figures are 25% unemployed, but the unofficial figures are more like 40% unemployed. This accounts for the high crime rate, as people and families struggle to feed and support themselves. And of course, Africa has a high HIV rate, malaria and tuberculosis as well as other common diseases which are endemic to Africa.

The group went to visit Table Mountain Cape Point and the Peninsular. This was originally thought to be the furthest point of South Africa.

Please see my AMAQ Conference pics on P8.

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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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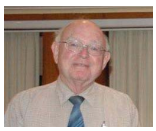

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RDMA 2014 MEETING DATE CLAIMERS:

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 13th November 2014
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NLMA 2014 Bi-MEETING DATE CLAIMER:

For all Northside LMA Meeting & Membership queries contact:
Meeting Convener:
Lucy Smith , QML Marketing Office,
Contact Details;
Phone: (07) 3121 4565, Fax: (07) 3121 4972
Email: lucy.smith@qml.com.au
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

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

ROYAL COLLEGE OF GENERAL PRACTITIONER (UK) CONFERENCE, LIVERPOOL 2014

This year, instead of treading the more accustomed conference trail, I attended the RCGP Conference in Liverpool, interested to compare the similarities and differences between us and the Brits. Although a GP conference, there were a lot of messages and warnings for Australian specialists as well. Funded by a large subscription base (there were 1700 attendees), it was a very professionally run conference which puts to shame the country-cousin conferences that I have attended on my home soil. Except for the catering, which was appalling (I recall the joke about Hell being a place where, inter alia, the cooks are English).

1. MINISTER FOR HEALTH. The opening plenary session included an address from the Right Hon Jeremy Hunt, Secretary of State for Health (translated, Minister for Health). There were no surprises, but a few cautionary tales for Australia. His presentation attracted a lot of negative flack on Twitter over the next few days. Most of his messages could have come from Australia, with a change in the position of the decimal place in the numbers (and deleting his references to NHS contracts). GP shortages, not enough money (but his portfolio was one of the few that is not shrinking its budget), GP burnout, not enough undergraduates choosing GP as their first choice, the ageing population, the ageing demographic of existing GP's, etc, etc. The word "capacity" kept echoing through his talk and those of many later speakers.

Excitingly, he recognized at several points in his presentation the efficiency of general practice – over 80% of NHS services are provided by GP's who cost just over 8% of the NHS budget (and that percentage is falling), and GP's are clearly identified as the most effective way of keeping patients away from more expensive services. Some differences were outstanding.

The assumption that nurses of various calibres were established as part of the primary care team is now well entrenched, with the assumption extending to nurses not employed by the practice. The next day, the Welsh Minister for Health expanded on this – "only do what only you can do", and leave the less complex tasks for advanced care nurses. I see much merit in this concept. GP's should be doing the difficult stuff that we were trained to do, and stop wasting time on the simple stuff that clinical assistants can do, as long as they are doing it at our direction and under our supervision. Britain has no problem of indigenous health disparity, but they do address social inequalities. I was bemused that their near-equivalent problem with itinerant populations included Gypsies and sex workers. An interesting statistic was that there is an 18-year gap in life expectancy between the lowest and highest socio-economic groups (another speaker cited a peak 27-year difference in Scotland). I could not help but compare the 17-year gap between indigenous and non-indigenous Australian life expectancy.

The NHS is having another (probably futile) attempt at addressing the problem of after-hours service delivery. Locum **Cont Page 4:**

INSIDE THIS ISSUE:

Dr Wayne Herdy AMAQ Report Cont:

services just haven't caught on, because of the funding arrangement based on capitation rather than fee-for-service. The new experiment is in "federations", basically cooperatives allowing groups of practices to share an after-hours roster. Patients will not necessarily see their own GP, but - and my ears really pricked up here – the GP will have access to the patient's computer-based record held by another practice. The UK does not have a complete SEHR, but this proposal assumes that data-sharing will occur.

On the issue of the "GP shortage", he recognized that much of the problem is maldistribution rather than shortage. He has commissioned a study to determine what numbers of GP's are needed and, interestingly, which areas have worst GP-patient ratios. It came as a surprise to me that the UK NHS is so late coming to this. From other delegates, I got mixed messages. All thought there was a GP shortage, many had difficulty recruiting and retaining partners, and some described not getting home until 10pm some nights, but most grumbled about the onerous workload of their 40-hour week. Excuse me?

He discussed transparency as a desirable aspect of the NHS. So far, so good, but he later went on to propose that "transparency" should include publication of doctors' incomes. The rationale was supposedly to dispel urban myths about doctors' incomes, the perception supposedly being that they are paid much more than they really are (average seems to be around GBP100,000 pa). Even if this is true, Australians would be profoundly disturbed by the potential invasion of privacy. Yet this proposal did not raise a murmur from the audience nor attract a single comment at question time. I remain bemused by the cultural difference that Brits have come to just accept proposals that would excite outrage in Australia.

A warning for Australia – he discussed the concept of hospital-based community care, which appears to include a presumption that GP's would eventually be managed by hospitals. He opposed this concept, but it seemed to be accepted by the audience that hospitals had a right to adopt such a role. In what I took to be a slip, he referred to doctors as included among "other public servants". There was no gasp from the audience, nor any challenge during question time (a vigorous question time in which he was, on another topic, called a liar). Although GP's here are not public servants, they seem to be resigned to the fact that they are indeed government employees without the collateral benefits.

2. CEO OF NHS. The plenary session on Day 2 featured Simon Stevens, the Chief Executive of NHS England, who has only just taken up his 5-year appointment. From the start of the day, I observed that his attendance attracted a higher level of security than did the attendance of the Secretary for State the previous day. He also attracted a protest by doctors in scrubs and masks at the entrance to the convention. It seems that the senior salaried public servant drew far more attention than the Minister – the executive officers in the UK wield more real influence and power than the elected representatives. Maybe he was being politically correct and Britishly polite, but he reiterated that it was time to take seriously the role of the GP. He described as "madness" the fact that in the past decade the NHS had seen an increase of 21% in the numbers of GP's but an increase of 76% in the numbers of hospital doctors. He had five main directions for his future agenda.

(a) The need to stabilize GP funding. The NHS has engaged in a series of funding experiments but not given enough time for any of them to make a real difference. This is a typically British solution to a dysfunctional organization – legislate it, rename it, staff it with the same people in the same building with the same infrastructure. Australian GP's are familiar with the difficulty of future planning when funding models keep changing – just recall the change in the practice nurse SIP to a more limited PIP, and its effect on our staffing and planning.

(b) He says that GP's should have more clout in planning. He stated that doctors, through CCG's, already control 2/3 of the NHS budget. CCG's are Clinical Commissioning Groups, devised in 2012 when they replaced Primary Care Trusts. ("Commissioning" means "purchasing".) Translate CCG into something like the old Australian Divisions of General Practice but with genuine involvement of virtually 100% of practices, and directing funding for elective hospital admissions. This of course is fundholding. At least it remains doctor-controlled.

(c) Workforce and workload planning needs to take into account the changing demographic of GP's, the increasing numbers of females, salaried, part-time and sessional doctors, and individual desires for career mobility. The NHS has simply failed to keep up with social changes which the Australian system accommodates comfortably. The changes that he had in mind related to NHS contracts and remuneration, which don't translate directly into the Australian environment.

(d) The NHS has to support new models of care. While acknowledging that no size fits all, he admitted that diversity and adaptability are presently poorly supported. While he paid lip service to independent practice, he appeared to favour a system that was ever closer to salaried practice. He spent some time discussing the emerging force of "federations", mergers of

practices, and expressed a view that larger federations might eventually include specialists. Watch this space – federations are a newcomer on the NHS scene and seem to be gathering some momentum. Shades of the New Zealand experience!

(e) He predicted a need for changed relationships with patients. This gave me much food for thought, mostly trying to read between the lines what he actually envisaged that he failed to verbalize. While I grew up in a familiar but ever-changing system, I am fond of the old doctor-patient therapeutic alliance, and I would have as much trouble as any traditional GP would have in changing the nature of that relationship. His most specific example was that patients should go to a pharmacy for over-the-counter advice and medications in the first instance for respiratory infections. Translating this into the Australian environment, that simple example raises controversies. I have to agree that most patients with RTI's don't need to see a doctor, but we are currently in a multi-levelled turf war and are reluctant to yield any ground to pharmacies, no matter how small, and we believe that most OTC cough and cold remedies don't do much good anyway.

But I don't think that this was all he had in mind when he listed changed patient relationships as one of his five top priorities. We might have got more of a clue at the end of the day when the Welsh Minister for Health and Social Services, Prof Mark Drakeford, spent some time expounding the hypothesis that the traditional model of transferring responsibility from the patient to the therapist does not work. This strongly suggests a developing policy of making patients take some responsibility for their health outcomes. It is also consistent with evidence cited repeatedly during the conference that health interventions are only responsible for 20% of the changeable component of health outcomes, compared with 40% contribution by social and lifestyle interventions.

3. OTHER SPEAKERS. The Care Quality Commission was prominent. The CQC conducts periodic inspections of practices, comparable with our GP practice accreditation process. However, the inspections are random rather than scheduled, and over 45% of practices are inspected in any 12-month period. Practices are given 2 weeks' notice of an impending inspection, but inspections can occur at zero notice if concerns are raised. Anybody can raise a concern. The CQC only looks at structure and administration of practices (appointment schedules and access and so on) and not at clinical competence (that is left to the GMC). They issue publications telling patients what to expect of their doctor's practice (but not so much what to expect of the doctor).

They aim to ensure quality and safety, but describe themselves more broadly as "the independent regulator of all health and social care services in England" (not the entire UK?). CQC was formed in 2009 by the merger of precedent bodies, has only been operating its present functions for about 2 years, and so far it claims that its role has been benign. However, a review of its website shows that about one in 3 inspections yields a "needs improvement" rating. A failure presumably carries penalties of loss of NHS funding. British doctors just seem to accept that the CQC has such potentially punitive force and powers. It takes little imagination to predict that such an organization could works its ways in a much more Draconian and authoritative manner.

Several speakers throughout the conference reinforced what I already knew, that British GP's just do not have the close personal relationship with their patients that we do. This outcome is counter-intuitive, since UK patients are more or less restricted to attending just one practice. Doctor shopping is possible, but not as readily facilitated as under Australian-style Medicare. Despite the fact that Australian patients have infinite choice of GP, we still have what looks like a more personal and intimate relationship with our regular patients. With all due respect to my UK hosts, I cannot help but wonder how much of their perceived inability to provide a personal relationship arises from their entrenched mentality that their GP's are really de facto public servants who work a 40-hour week and do not expect to do anything above and beyond average-level care.

One outstanding cultural difference struck me. British GP's are surprisingly reluctant to raise with their patients the question of obesity and weight management. As far as I am aware, Australian GP's are not overly sensitive about asking patients to stand on scales.

I attended a session on telephone triage, expecting something like 1300HEALTH. In fact, this is triage by GP's in their practices for the first hour of the day. The NHS permits GP's to perform telephone consultations, which resolves something like 60% of patient encounters within less than 5 minutes. The process substantially reduces the number of face-to-face consultations and dramatically reduces wait times for the next appointment. Surprisingly, patient continuity improves. This suggests an argument in favour of Medicare schedule rebates for telephone consultations, and a partial answer to the perceived GP workforce shortage.

Other speakers raised themes familiar to Australians: GP-bashing, the need to do more and more with less and less, a 3-week wait for a routine appointment, falling job satisfaction.

Dr Wayne Herdy's Report Cont Page 6:

AUSTRALIAN MEDICAL ASSOCIATION QLD PRESIDENT
Dr Shaun Rudd

Dear members,
As you are likely aware, the Department of Health recently released the boundaries for the new Primary Health Networks that will replace Medicare Locals from 1 July 2015. Since the announcement of the establishment of PHNs, AMA has worked with the Government to develop a system that is more efficient and viable than the Medicare Local scheme.

A key concern of AMA and AMA Queensland is ensuring the new system places GPs at the heart of primary healthcare. We need to make sure the mistakes that happened with Medicare Locals do not recur. In order for that to happen, GP leadership and clinical input will be paramount.

Considerable unknowns remain about how the Primary Health Networks will operate. Vigilance will be needed to ensure the new system makes healthcare more accessible for patients and that there is not a degradation of services, particularly in rural and remote areas.

The boundaries drawn for Primary Health Networks reiterate these concerns, with networks covering expansive geographical scopes. Comprehensive checks and balances will be needed to ensure services do not fall through the cracks.

In the coming months, we will continue to monitor the development and implementation of Primary Health Networks and work with government to develop a model that is sustainable and beneficial to patients.

The new Primary Health Networks are just one indication of the shifts occurring in primary healthcare in Queensland and across Australia.

Increasing the scope of allied health professionals has been widely debated lately, with the intention of making healthcare quicker and more accessible. While we agree these are important characteristics of an efficient and sustainable healthcare system, it shouldn't come at the cost of patient care.

Doctors, nurses and pharmacists all play vital roles in our healthcare system, and these roles work best when they complement each other rather than substitute each other.

Both of these issues point to the changing landscape of healthcare, which you have likely seen in your own medical career. These changes show no sign of slowing down, and it is more important than ever that AMA and AMA Queensland continue to work with government, stakeholders and members to deliver the best healthcare system for Queensland and Australia.

You will soon be receiving a notice to renew your membership if you haven't already. Your membership is one of the easiest ways to contribute to the medical profession and I urge you to take a few moments to renew for 2015.

We have had some key wins over the last year which we have outlined in our renewals letters and these would not have been possible without the support of our members. There is still work to be done, and in 2015 we will continue our vital advocacy work developed with member feedback in mind.

Sincerely,
Dr Shaun Rudd, AMA Queensland President

Dr Wayne Herdy AMAQ Report
Continued from page 5:

A session on comparison of many health systems world-wide determined that the best health outcomes will always result in systems that deliver health care at a point closest to where it is needed. Around the world, community-based primary care remains the gold standard of efficient effective health care. Politicians the world over are slowly recognizing the value of primary care.

And finally, pervading the conference was a theme that the UK NHS was the best system in the world and the envy of other nations. Sorry, mates, but I just don't see that. Their wait times are the same as ours, their consultation times are shorter, their access hours are much shorter, they have much narrower scopes of practice, and despite their bleatings I cannot see that they have the personal relationship that I have with my patients. They repeatedly cite high levels of patient satisfaction as proof of their success, but is that not a universal finding in the health industry? And our outcomes are better, our life expectancy is longer than theirs, achieved with a much lower percentage of GDP.

I came home with the self-righteous belief that Australia still has one of the best health systems in the world.

Wayne Herdy, Branch Councillor North Coast Area Representative

MORETON BAY RADIOLOGY

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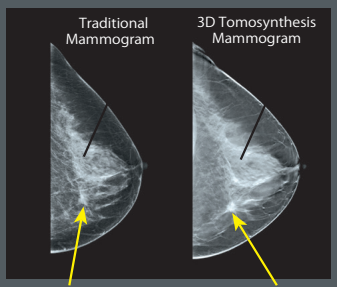

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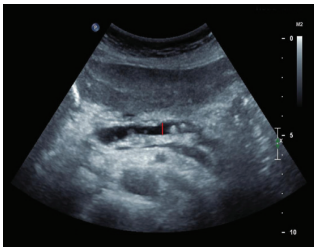
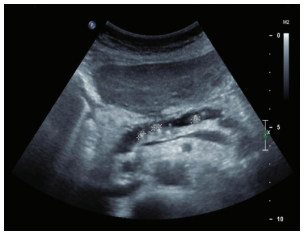
MORETON BAY RADIOLOGY

Chronic Pancreatitis

Findings

Atrophy of pancreatic parenchyma and irregular dilated main pancreatic duct and side branches giving chain-of-lakes appearance. Multiple foci of coarse calcification are seen in pancreas with few intraductal calculii. Decreased pancreatic enhancement during arterial phase with delayed enhancement during portal venous phase.

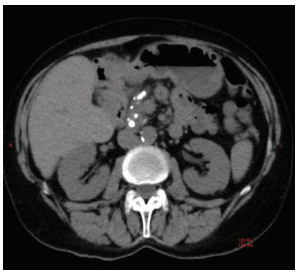




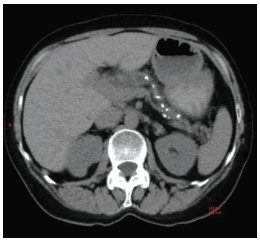
Diagnosis

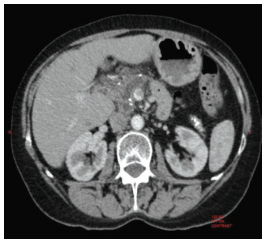
Chronic Pancreatitis.

Discussion



Chronic pancreatitis is an inflammatory disease characterized by progressive and irreversible structural damage to the pancreas resulting in permanent impairment of both exocrine and endocrine functions. Chronic alcoholism and gall stones are the two most common causes. ERCP is the gold standard for early chronic pancreatitis, but it is invasive. CT and MRI may be an alternative for patients in whom ERCP is contraindicated or not tolerated. Ct and MRI provide noninvasive biliary and pancreatic duct imaging and accurate characterization of pancreatic and peripancreatic pathology.





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American Journal of Roentgenology. 2004;183: 1645-1652. 10.2214/ajr.183.6.01831645

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AMAQ BRANCH COUNCILLOR REPORT GREATER BRISBANE AREA

Dr KIMBERLEY BONDESON

Co-Payment Legislation & Medical Graduate Numbers & AMAQ Conference Pictorial

Co-Payment Legislation

It appears that the Legislation for a co-payment on GP services has been withdrawn.

There has been no explanation from the Health Minister's office for this, but a spokesman for Mr Peter Dutton has stated that there was no urgent need to present the legislation.

Medical Graduates

We have all been aware that there is at some stage going to be a shortfall in medical intership placements in Australia.

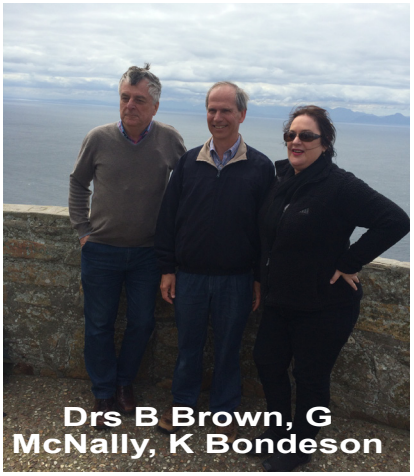
Research from the National Medical Intern Data Management Working Group has indicated that about 240 foreign-born Australian graduates will miss out in intern places in Australia in 2015.

AMAQ Conference Pictorial
Continued on Page 20

Dr Kimberley Bondeson, AMAQ BRANCH COUNCILLOR,

African Dancers Victoria Falls

Driving out of Capetown to the TableMountainsFalls



Drs B Brown, G McNally, K Bondeson

Signpost at the tip of Africa

Elephants in Botswana

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 2
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.

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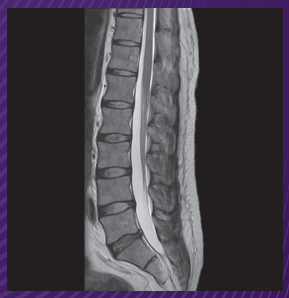

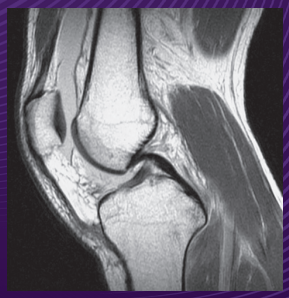

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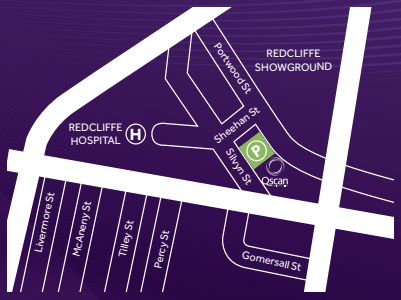

TRUSTED ANALYSIS

Narangba Family Medical Practice

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.

We are a three doctor, fully computerised, non-bulk-billing practice established since 1986 in an outer, semi-rural northern suburb of Brisbane. The ideal candidate would be of an age where taking over the whole practice eventually would be a distinct possibility.

Contact: Dr Peter C. Stephenson,
Email: PCS1@narangba-medical.com.au
Mobile: 0403 151 602.

Practice Phone & Location: Phone: 07 3886 6889, Opposite the Narangba Railway Station, Main Shopping Centre, beside the Narangba Pharmacy.
Street Address: 30 Main Street, Narangba Q 4504.
Postal Address: P.O. Box 3 Narangba Q 4504

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For more information, please contact Tracey Blackmur
P: 0438 855 321 E: Tracey.Blackmur@qml.com.au.

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Motoring Article #113
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"Gain On Disposal" Selling Your Car

With years of low inflation, strong competition and a high Aussie dollar it's never been cheaper to buy a new car. And after getting a great deal on the purchase price the cost of acquisition is further reduced by claiming back the GST and the very generous depreciation allowances provided by the ATO for business users.

Until 31st December 2013 the accelerated depreciation meant business owners could claim $5,000 plus 15% of the cost-base balance in the first year and 30% of the diminishing value every year thereafter.

This arrangement was due to end with the passage of the Minerals Resource Rent Tax Repeal and Other Measures Bill 2013. As that Bill is not proceeding it looks like the generous motor vehicle tax deductions are still available. Those deductions have been so generous over the years that it was possible that your trade-in was still worth more than its depreciated written down value.

When a car is sold for more than its depreciated written down value there is said to be a "gain on disposal". That is some of the tax previously refunded will need to be re-paid. For taxation purposes this amount can also be off-set against un-deducted funds in the capital pool. Those un-deducted funds might relate to the purchase of a previous vehicle that cost more than the Luxury Car Limit which is currently $57,466. For a full explanation of this seek professional financial advice.

Low prices, long warranties and new technology really do make the arguments for trading up irresistible. But those of us who already have wheels will have to decide what to do with our current vehicle. Of course trading your car in will always be the easiest and most convenient option.There are none of the hassles of advertising, finding a buyer, test-drives, haggling and the annoyance of those who are just looking.

But dealerships make a living from what they do and there are times when that trade-in figure will be painful. All of those cheap new cars mean that used car values are also very depressed and there are really some great bargains out there for those with the time to shop around.

A case in point is a colleague's recent purchase of a new C Class Mercedes. He found that new car smell irresistible and the new model is a significant up-grade over and above his "old" 2012 C Class. Anxious not to lose a sale on the new car the dealer warned my colleague that there would be no good news on the trade-in price with his current car having depreciated by 50% in only two years (ie much faster than the tax write-off). It's all a reflection of the laws of supply and demand.

The new C Class has gone up marginally in price, but it's loaded with more technology, automated braking and is 100 kg lighter making the superseded model yesterday's technology. To sweeten the deal the salesman offered to help my colleague sell his car privately. After all the Redbook said he'd be able to ask about $9,000 more than the dealer would offer and his old car was in pristine condition, still under the manufacturer's warranty and had only 14,000 kilometres on the dial. My colleague left his car at the dealership for the morning and took a demonstrator vehicle for the day.

The dealer at their expense did a safety inspection/road-worthy ($77), detailed his vehicle, photographed it and up-loaded the details ($115) to one of those internet sites that's sending printed newspapers broke. All was done and now he just had to wait for the phone to ring off the hook.

Two weeks later. Perhaps the market for second-hand Mercs collapsed at the moment his vehicle's details were up-loaded, but it is still for sale as this is written. It's such a good car he might just change his mind and keep it after all.

RDMA September Meeting 17.09.2014 Sponsor: Monserrat

Day Hospital North Lakes. Chair President Dr Kimberley Bondeson Speakers: Dr S Islam Topic: H. Pylori Infection-Tricky Aspects; Dr D Thaker Topic Breast Cancer Screening-Whats New

LEFT: Sponsors: Monserrat Day Hospital Trish Mukaushas, Nadine Carlson, Melanie Moody
CLOCKWISE; Matthew Blackstone New Member & (Speaker) Darshit Arunlehai Thaker. Speaker Shamsul Islam. Geoff Harding & Ken Fry. Janice Veira, Pravin Kasan, Lydia Nowlem & David Coe New Members. Leena Moisander & James Rigano New Members. Jocelyn Chan & Angela Smith New Members.

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

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: Tuesday 28th October

Time: 7 for 7.30pm

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

Cost: Financial members - FREE, Doctors in training - 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 Kimberley Bondeson - President RDMA Inc.
7.35pm	Sponsor: GSK
7.40pm	Speaker: Dr Sumant Kevat, Rheumotologist Topic: PROLIA® (denosumab) – "Making an impact in osteoporosis management"
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 24th October 2014

QML Pathology.

Banksia Beach MEDICAL

Job Vacancy

We are looking for 2 Full-time VR GP's for our practice. One of these positions is to fill one of our outgoing (female) doctors.

We are a three doctor practice (currently), fully computerised, bulk-billing practice with one fulltime Registered Nurse and three very professional Reception staff.

Banksia Beach Medical is located on beautiful Bribie Island, Queensland.

Bribie Island is connected to the mainland by bridge and is only 45 minutes from Brisbane. As you cross the Bribie Island bridge you have stunning views of Pumicestone Passage and the majestic Glass House Mountains .Banksia Beach Medical is located at the Bribie Harbour Shopping Village, Banksia Beach which is only 5 minutes from the prestigious Pacific harbour Golf and Country Club and walking distance to the Pumicestone Passage.

Our Mission is to provide the highest standard of patient care incorporating a holistic approach toward diagnosis and management of illness. Our practice is committed to promoting wellness and disease prevention to all patients. We do not discriminate in the provision of excellent care and aim to treat all patients with due respect.

Please contact Mrs Vikki Ward 3408 6822/0410 077 001

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BURPENGARY GP / MEDICAL CENTRE

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A full time GP is required at Burpengary Family Medical Practice. It is a busy practice, fully computerised and a very friendly atmosphere. One female GP is already working. No after-hours or weekends shifts. If the doctor is interested a partnership can be arranged. Days and hours are the doctor's own choice. The clinic is close to a pharmacy and other allied health services.
Contact: Dr.Haroon Chaudhary
Email: mahin_saim@hotmail.com
Mobile: 0422606379
Practice Phone: 38883766
Address: 33 Progress Road, Burpengary

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Burpengary	07 3888 2447	Oxley	07 3295 5560
Caboolture	07 5499 3891	Peninsula	07 3284 7999
Caloundra	07 5438 5959	Redcliffe Ultrasound	07 3283 3997
Chermside	07 3359 7177	Richlands	07 3879 3730
Holy Spirit Northside	07 3256 3322	Sandgate	07 3269 9165
Inala	07 3278 9644	Southport	07 5680 0060
Indooroopilly	07 3871 4300	Springfield	07 3413 7760
Ipswich Riverlink	07 3413 6660	St Andrew's Hospital	07 3839 5433
Ipswich Limestone St	07 3413 3133	Strathpine*	07 3889 6999
Maroochydore	07 5443 8660	Toowoomba	07 4642 2060
Mt Ommaney	07 3376 1500	Tweed Heads South	07 5669 1360
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Hospital Fax: (07)3491 3614 | Consulting Suites Fax: (07)3491 6803
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Brisbane Haemorrhoid Clinic 07 3833 6707

Brisbane Hernia Clinic 07 3833 6786

ENT Surgery
Dr David McIntosh..... 07 5451 0333

Endocrinology
Dr Deepali Shirkhedkar..... 07 3833 6765

Fertility Treatment My IVF .....1800 4 MY IVF

Gastroenterology
Dr Agus Brotodihardjo 1300 513 255
Dr Sam Islam 07 3833 6701
Dr Antony Pan 07 3833 6701
Brisbane Gastroscopy and Colonoscopy 07 3833 6701

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Dr Naeem Khan..... 07 3833 6765
Dr Hugh McGregor 07 3283 4200
Dr Daniel Mehanna 07 3833 6765
Dr Wijaya Premaratne 07 3833 6765
Dr Roderick Borrowdale 07 3283 4200

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Dr Moemen Morris 07 3833 6765
Dr Mahilal Ratnapala 07 5495 9546
Dr Archna Saraswat..... 1300 780 138
Dr Lata Sharma 07 3833 6765
Dr Namrata Bajra 07 3353 9090
Dr Graham Tronc..... 07 3870 5602

Occupational Medicine
Dr Robert McCartney ..... drrob@omcd.com.au

Oncology & Haematology Clinic.. 07 3859 0690

Open Access Endoscopy
Dr Sam Islam 07 3833 6701
Dr Hugh McGregor 07 3833 6701
Dr Daniel Mehanna 07 3833 6765

Ophthalmology
Dr Andrew Smith..... 07 3385 0900
Dr Stuart Reader..... 07 3385 0900
Dr Kate Slaughter..... 07 3385 0900

Oral & Maxilofacial
Dr Matthew Hawthorne..... 07 3852 4888
Dr Richard Harris..... 07 3852 4888
Dr Mohammed Mansour..... 07 3832 3232
Dr Terrence Alexander..... 07 3832 3232

Orthopaedics
Dr Gaugin Gamboa (Knees) 07 3832 1652
Dr Greg Farmer (General)..... 07 3883 2244

Pain Management
Dr Jason Kwon..... 07 3833 6701
Dr Frank Thomas 1300 724 625

Plastic Surgery
Dr Phil Richardson..... 1300 789 240

Physiotherapy
Bodyworks Physiotherapy..... 07 3204 6388

Queensland Vasectomy Clinic 07 3833 6701

Rheumatology
Dr Mukhlesur Rahman..... 07 3833 6765

Urology
Dr Jo Schoeman..... 07 3831 9049

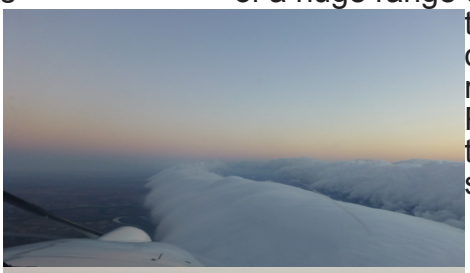
Be Our Guest
www.montserrat.com.au

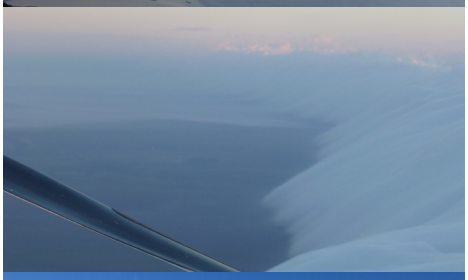
The Morning Glory.

By Peter Stephenson

Readers may remember an article in RDMA newsletter some three years ago about the trials and tribulations of my 60th birthday present to myself of a motor-glider. Well, the main goal of getting the motor glider was to use it to fly it to soar the Morning Glory, and amazing cloud formation that occurs in September/October every year above Burketown in North-West Queenland. Well, I had it lined up to go last year but literally at the last minute, the aircraft was grounded by having to have the propellor overhauled because it had not been done for six years. :-(It had plenty of hours to run on it though!

This year it really happened. My wife and I flew up to Burketown on the 25th-27th September with minimal problems, staying in Emerald and Winton. The weather was pretty good, and the trip from Winton to Burketown had an up to 25 knot tail wind which was absolutely magic, shortening the trip by 20%!
Arriving on the Saturday, we settled in to the Savannah Lodge which is just like an oasis around a swimming pool. Our cabin was perfect and had two air conditioners to keep us cool.





The Morning Glory (MG) arrives early in the morning, and is not a guaranteed phenomenon, so I was up in the dark at 5am on Sunday morning, leaving Gabrielle to catch up with her sleep. Sunday was a total non-MG day. But we still had a flight at 1pm which was part of a flypast over the town by five motorgliders. This was part of the MG Festival that was paid for by the local Council, which included a BBQ/ Hangi cooked turtle and dugong, which we partook after our flight. They emphasised that both meats were not endangered species in the

local area, and we saw dugongs galore from the air. The meats were very soft but did not have distinctive tastes. The locals were really great to us. Very polite and respectful and no aboriginal drunkeness was seen. However, one caucasian drunk came up and gave me a hug and called me his father. There was also a dance troop from Mornington Island which put on a display of a huge range of dances and I wondered how they remembered the myriad of steps. There were many rock bands playing that day. Politicians took advantage of the occasion to bore us with speeches, which was sad.

Monday was the day!. Gabrielle came with me this time and with the early dawn light at 6am, looking north east there was a large MG approaching slowly. It was all go to get into the air with all 8 motor gliders rushing to take off. We climbed to 3000' and headed forwards to this brooding cloud. The MG rolled under us and we switched off the motor and the grins just started. Two and half hours of pure joy. We headed north west towards the Northern Territory border when we turned around and headed back south east. We then hopped over the primary MG and onto the second MG and then the third MG as this was the direction where Burketown was (North East). The MG's are usual lined up in three parallel lines with the clouds moving at about 35klms at right angles. Amazingly the lift is in front of the direction of movement and is a relatively rolling in the opposite direction, and this is what keeps us up. Our third MG was not as well developed as the first and second, but had the most lift in front of it. What a thrill! and then we had to turn the engine on and fly home as I was busting for a pee and to have breakfast.

So looking at the tacho, we were up for 2 and half hours and we had the engine on for only 30 mins. Felt like 60 mins.

Well, that is off my bucket list! :-(

PS I have the whole flight on GO-Pro to relive the experience!

Metro North Hospital and Health Service
Redcliffe Hospital

Queensland Government

Enquiries to: Craig Margetts
Director of Medical Services
Telephone: (07) 3883 7508
Facsimile: (07) 3883 7528
Our Reference: CM:sh

To all GPs in the broader Redcliffe area

Dear Colleagues,

Redcliffe Hospital is expanding its elective paediatric surgery.

We are extremely fortunate to have talented paediatric surgeons, who can offer general and orthopaedic surgical services to our paediatric patients.

Dr Craig McBride,
Senior Staff Specialist Paediatric Surgeon
Children's Health Queensland

Dr Hugh McGregor,
Surgical Consultant
Redcliffe Hospital

Dr Sheanna Maine,
Orthopaedic Consultant
Redcliffe Hospital and
Staff Specialist Paediatric Orthopaedic Surgeon
Children's Health Queensland

Redcliffe Hospital will be **accepting referrals** from the Peninsula and surrounding suburbs (north of the Pine River to the Glasshouse Mountains) **for paediatric surgical and orthopaedic cases** within scope.

The referral process for Redcliffe Hospital paediatric surgical patients will remain in line with the Metro North Central Patient Intake (CPI) process of electronic referral or Fax 1300 364952.

1. Paediatric surgical referrals from our designated catchment area will be forwarded to Redcliffe Hospital for triage and categorisation by Dr McBride, Dr McGregor or Dr Maine. Children requiring tertiary level services, or prolonged inpatient care, will have their operations performed at Lady Cilento Children's Hospital. Where appropriate, outpatient care will be conducted at Redcliffe Hospital.
2. In line with Medicare requirements, as this is a **new** dedicated paediatric service, **only named referrals** will be accepted, but patients will be bulk-billed so there will be no out of pocket expenses. Please name the paediatric referrals to:
   - Dr Craig McBride, Paediatric Surgery Redcliffe Hospital for paediatric surgical referrals
   - Dr Hugh McGregor, Paediatric Surgery Redcliffe Hospital for paediatric surgical referrals
   - Dr Sheanna Maine, Paediatric Surgery Redcliffe Hospital for paediatric orthopaedic referrals

For any enquires about this service please contact, Nurse Unit Manager Specialist Outpatients Department, Redcliffe Hospital. We are looking forward to providing an invaluable service to our community and caring for your patients in the near future.

Regards,

Dr Craig Margetts
Director of Medical Services, Redcliffe Hospital
08/10/2014

Office
Redcliffe Hospital
Anzac Avenue
REDCLIFFE Q 4020

Postal
Locked Mail Bag No. 1
REDCLIFFE Q 4020

Phone
(07) 3883 7777

Fax
(07) 3883 7528

New Zealand

By Cheryl Ryan

Besides its diverse and stunning natural beauty, New Zealand is also famous for boasting some of the world's finest culinary treats and most savory wines. As a matter of fact, a great number of Foodies and Oenophiles consider New Zealand as their ultimate slice of heaven on earth.

Come with me, as we take you to a gastronomic journey from the most talked about Pacific Rim cuisine to the long stretch of wine vineyards all throughout the country.

The Traditional Hangi Cooking Method
Take a bite of New Zealand's food culture by experiencing a Hangi feast. Hangi is a traditional way of cooking food that was introduced by the Maori natives. It uses heated rocks and wet sacks to slowly cook wrapped meat and vegetables in an underground pit oven. Experience the Maori culture and delight yourself in a Hangi feast by visiting Tamaki Maori Village in Rotorua.

The Modern Pacific Rim Cuisine
The Modern Pacific Rim cuisine is a mouthwatering medley of fresh local produce from the freshest mussels to the juiciest, best-tasting roast lamb. Kiwis love to jazz their food with unusual twists but equally appetizing and pleasing to the palate. They like infusing herbs and spices to add flavor to their contemporary dish. Their cuisine is a playful fusion of British, Asian and Maori flavors.

Wine Tasting Adventure
New Zealand has a long stretch of vineyards reputed as the best wine-producers in the world. It is believed that Kiwis owe their high-quality wines to their climate which lengthens the ripening period. This accounts for their wines to age gracefully.

Taste your way to the classic wine trails from Hawke's bay in the North to Marlborough in the South. These wineries don't only have the best tasting wine, but they also produce the finest cheese.

The Bustling North Island
The Bay of Islands is a playground for beach lovers and water athletes. Here , you may swim with the dolphins, sail a yacht, go on a boat cruise, forest hikes, helicopter tours or simply lay your towel on the beach as the soothing sound of the waves melt your worldly worries away. After enjoying beach and sand, let us go back in time and visit Waitangi Treaty Grounds, which is one of New Zealand's most significant historic sites.

There are a lot of things to do and enjoy in the Hamilton-Waikato region. For one, the Hobbit-sized village and the lush greeneries that you see in the Lord of the Rings movie was filmed here. The Waitomo Cave is also a must-see attraction, as it is also home to light-emitting glow worms, which give the cave's stalactites and stalagmites a stunning glow. It is indeed a sight and beauty to behold!

Southside Adventure at Queenstown
Known as the Adventure capital of New Zealand, Queenstown offers a wide range of activities. For those who fancy a mid-air adventure, bungy jumping, swinging and flying fox are all available. If water adventure is more of your thing, you can do whitewater rafting, river surfing and canyon swinging. But if that is not thrilling enough for you, try doing some skydiving, paragliding, snow skiing or hang gliding.

Where ever you want to go in New Zealand we can arrange it for you.
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22 September 2014

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www.agpal.com.au

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

Dear Dr Mohanlal

RE: ETHNICITY OF PATIENTS IN ACCREDITATION REQUIRED FOR THE CURRENT TRIENNIUM

Thank you for your correspondence dated 6 September 2014 highlighting your concerns regarding the *ethnicity of patients in accreditation required for the current triennium* that appears as a tick box in the latest version of Medical Director and Pracsoft.

Whilst AGPAL is unable to comment on the specifications or terminology relating to clinical software, AGPAL is in a position to provide clarification of the RACGP *Standard 1.7 - Content of patient health records; Criterion 1.7.1F: our practice can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records.*

The aforementioned criterion is an unflagged indicator for this Standard therefore is voluntary for a practice undertaking accreditation. The intent of the RACGP Standards is to encourage the identification of a patient's cultural background to assist General Practitioners with patient care through highlighting potential clinical risk factors that may be associated with a particular cultural background.

We will raise this matter at the RACGP Standards Liaison Committee (SLC) meeting to be held in November. As the RACGP is the Standards owner, you may wish to raise this matter with them directly.

Yours sincerely,

Dr Stephen Clark
Group CEO
AGPAL Group of Companies

Attention business owners! Did you know that as a director of a registered business entity, a corporate travel policy is valid for both your business and your leisure travel? The cover can also include additional business executives and other employees on the move.

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A cost effective, single annual policy takes care of all trips by the frequent business traveller, and nominated additional travellers, within the policy period. No longer do you need to think about travel insurance every time you plan a trip. Buy once, then forget it and travel with peace of mind knowing you're covered for just about any eventuality.

The benefits go well beyond cover offered by a retail or credit card travel policy. As well as the professional service you would expect, there are significant benefits in Corporate Travel cover including coverage for pre-existing conditions and cover for travellers over 65 years of age. Upper age limits vary from underwriter to underwriter.

To obtain a quotation or further information on Corporate Travel Insurance, contact Jennine Sellers at Poole General Insurance Brokers on 0754379900 or email jsellers@poolegroup.com.au

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T: (02) 6270 5400 F (02) 6270 5499
Website : http://www.ama.com.au/

"POLITICIANS, DOCTORS, POLICE, PUBLIC HEALTH EXPERTS, AND FAMILIES OF VICTIMS TO MEET TO DEVELOP ACTION PLAN TO ADDRESS ALCOHOL-RELATED HARMS" Twitter hashtag - #AMAsummit

AMA National Alcohol Summit, National Convention Centre, Canberra, 28-29 October 2014

The AMA is next week hosting a major national summit in Canberra to examine Australia's unhealthy and dangerous alcohol culture, and to develop an action plan with practical solutions that will ultimately save lives and improve the health and quality of life of millions of Australians.

The AMA National Alcohol Summit will look at the impact of excessive alcohol use across several different domains including alcohol-related violence and the social costs of alcohol; culture, advertising and sport; the harmful use of alcohol in Indigenous communities; and Fetal Alcohol Spectrum Disorder.

The Summit will bring together political and community leaders, medical and health experts, police, families of victims, and other stakeholders to share ideas and experiences and propose practical measures to reduce the often devastating harms that alcohol abuse brings to families and communities.

Key Summit speakers include Federal Opposition Leader, the Hon Bill Shorten MP, Australian Greens Health Spokesman, Senator Richard Di Natale, Australia's leading public health experts, and Mr Ralph Kelly, father of Thomas Kelly, who tragically died as a result of senseless alcohol-related violence on the streets of Sydney.

AMA President, A/Prof Brian Owler, said today that a national summit on alcohol and its harms is long overdue.

"The AMA early this year called on the Australian Government to host a summit at a time when the Australian community was reeling from a series of violent alcohol-fuelled attacks," A/Prof Owler said.

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

"When the Government failed to act, the AMA decided to stage its own Summit and bring together a broad range of knowledge and experience from across the community.

"We will not be calling for a ban on alcohol or for people to give up alcohol altogether. But we will be calling for a national rethink of Australia's historical alcohol culture, and a fresh approach to dealing with alcohol in a safer and more responsible way.

"And we will be calling on the Australian Government to take a strong leadership role in reshaping the relationship between alcohol and the Australian community."

A/Prof Owler said the AMA has been a consistent public voice in raising awareness of alcohol-related harms and the need for a comprehensive national response with practical actions and solutions.

"As doctors, we are often at the frontline in dealing with the effects of drinking. We see the physical, mental, and social harms every day of the year in our surgeries and emergency departments across the country. We have to end this national tragedy before it engulfs yet another generation of Australians."

20 October 2014

CONTACT:

John Flannery
02 6270 5477 / 0419 494 761

Odette Visser
02 6270 5464 / 0427 209 753

Follow the AMA Media on Twitter: http://twitter.com/ama_media

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

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription Benefits

Don't waste time! Join now!

Monthly: Newsletters, Topical Educational Meetings, 3 Course Cuisine,

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Rounded off with the End of Year Networking Meeting

Get your membership benefits! Socialise! Broaden your knowledge!

Dear Doctors

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.

RDMA SUBSCRIPTION FORM – INTERNET PAYMENT PREFERRED

Treasurer Dr Peter Stephenson Email: GJS2@Narangba-Medical.com.au.

ABN 88 637 858 491

1. **One Member (July to June: $100; Oct.-June: $75; Jan-June: $50.00; April-June: $25.00)**
2. **Two Family Members ($25 Discount each) ($150 pro rata)** (Please supply details for both members)
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. **PREFERRED INTERNET BANKING**
2. **PAYMENT BY DEPOSIT SLIP**: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. **ENCLOSED PAYMENT:** (Member Subscription Form on website, type directly into it 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 Work And Live

Above: My sister at Victoria Falls, on the Zambabwe side The falls you can see are in Zambia.

Near Capetown

Victoria Falls

The AMAQ Conference Pictorial
Capetown Africa September 2014

Seals lying on a Pontoon at Seal Islands near Capetown

Elephants in Botswana

Giraffe & Elephants in Botswana