RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
OCTOBER 2016

Variety Bash 2016 Update by Dr Wayne Herdy 30/090-9/10/16 Page 20

See Where We Work & Live on page 20.
The Queen of the Colonies Continues:

President's Report Dr Kimberley Bondeson

I have just returned from another fantastic AMAQ conference, this time in India. We started in New Delhi, then visited the city of Agra (visiting the Taj Mahal, and then onto Jaipur. What an incredibly diverse country. We had some wonderful guest speakers, including India's Health Minister, and several senior Indian Professors of Medicine, both clinicians and lecturers (pictorial on Page 9).

One thing that struck me, was the average life span of the Indian people, this is now 66yo, whereas 20 years ago, it was 46yo. This increase in life span has been put down to several reasons, the main one being public health issues. Unfortunately, as the Western diet has been introduced to India, complications associated with this, such as diabetes and coronary artery disease have also developed amongst the population. So the main cause of death has changed, from communicable diseases to non-communicable diseases.

It was spectacular to see the cows and occasional bull wandering the streets in India. I had only heard about it previously, but witnessing it was another thing. It was explained that it against the law in India to eat beef or to harm a cow. It was also explained that when some of the population state that they are eating beef, they are actually eating buffalo. The cow is considered sacred, as supplies milk and therefore milk products, which feed and sustain the nation. Each cow that seemingly wanders the streets in India actually belongs to someone. The cows are fed and milked in the morning, and let free to roam the streets during the day. It will then return to its home, to be fed and milked again. It was an amazing sight to see a large cow, sitting comfortably in a shop entrance, paying no attention to the local people around it going about their daily business. Apparently the reason the cow was sitting in that particular spot, was because it was the coolest place in the crowded street, normally an air conditioned shop front doorway. As the temperature whilst we were in India hit above 45 degrees during the day, I think the cows have got it right.

The Taj Mahal was also amazing, more amazing and spectacular in reality than how it appears in pictures or film. The love story behind the building of the Taj Mahal is one etched into the fabric of Indian history. One of the kings built it to honour his 3rd wife, and his true love, who died in childbirth.

One other thing I found incredibly interesting was when I purchase a compass, (a brass one, looked antique to me), at one of the markets. Dr Herdy did the bargaining, which by the way, he is extremely good at! When we got back to the hotel, my husband noticed it had an inscription on it, which we had not noticed. It read "It was 20 years ago today, Sgt Pepper taught the band to play. They've been going in and out of style but they're guaranteed to raise a smile. So may I introduce to you the act you've known for all these years Sgt. Pepper's Lonely Hearts Club Band."

This quote has of course, come from the famous Beatles Sgt Pepper's Lonely Hearts Club Band album. This fascinated me. I was extremely

Continued on Page 10 & 11

RDMA & NLMA's Joint Newsletter

Welcome from

Dr Robert (Bob) Brown

President Northside Local Medical Association

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

RDMA Executive Contacts:

President:
Dr Kimberley Bondeson
Ph: 3284 9777

Vice President & AMAQ Councillor:
Dr Wayne Herdy
Ph: 5476 0111

Secretary:
Dr Larry Gahan
Ph: (07) 3265 7500

Treasurer:
Dr Peter Stephenson
Ph: 3886 6889

Meetings' Convener:
Mrs Margaret MacPherson
Ph: 3049 4444

Newsletter Editor: Dr Wayne Herdy
Ph: 5476 0111

Advertising information is on RDMA's website www.redcliffedoctorsmedicalassociation.org/
please contact **Newsletter Publisher.**
Email: RDMAnews@gmail.com
Mobile: 0408 714 984

NLMA Executive Contacts:

President:
Dr Robert (Bob) Brown
Ph: 3265 3111
E: drbbrown@bigpond.com

Vice President: tbc

Ph:
E:

Secretary:
Dr Ian Hadwin
Ph: 3359 7879
E: hadmed@powerup.com.au

Treasurer:
Dr Graham McNally
Ph: 3265 3111
E: gmcnally1@optushome.com.au

Meetings' Convener: TBC
Dr Graham McNally
Ph: 3265 3111
E: gmcnally1@optushome.com.au

RDMA 2016 MEETING DATES:

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

Wednesday	February	24th
Tuesday	March	29th
Wednesday	April	27th
Wednesday	May	25th
Tuesday	June	28th
Tuesday	July	26th
ANNUAL GENERAL MEETING - AGM		
Wednesday	August	24th
Tuesday	September	13th
Wednesday	October	26th
NETWORKING MEETING		
Friday	December	2nd

RDMA NEWSLETTER DEADLINE

Advertising & Contribution 16 NOVEMBER 2016
Email: RDMANews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

NLMA 2016 MEETING DATES tbc:

For all queries contact Graham McNally
Meeting Convener: Phone: (07) 3121 4029
Email: gmcnally1@optushome.com.au

W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants

Time: 6.45 pm for 7.15 pm

1	February	16th
2	April	12th
3	June	7th
ANNUAL GENERAL MEETING - AGM		
4	August	9th
5	October	11th
6	December	13th

Next Meeting Date 26th October 2016

13.09.16 Dr Kimberley Bondeson, President Redcliffe & District Local Members Association introduced Dr Graham Hay-Smith from Moreton Eye Group, the Sponsor Representative for the night.

Dr Graham Hay-Smith was the Speaker for the night and his Topic: 'Better Management of Diabetic Patients Opthalmic View".
Below Top Down:
1. Speaker Dr Graham Hay-Smith.
2. New RDMA Secretary Dr Larry Gahan
3. Dr Gurmit Uppal
4. Dr Vern Haezlewood and Dr Terrance Casey
5. New Member Dr Genevieve Casey.

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 26th October**

TIME: 7 for 7.30pm

VENUE: Regency 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 Kimberley Bondeson - President RDMA Inc.
7.35pm	Sponsor: Seqirus
7.40pm	Speaker: Dr James Smith, Public Health Physician Topic: The changing landscape of adult immunisation & Zostavax on the National Immunisation Program
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: By Friday 20th October 2016
(e) Margaret.macpherson@qml.com.au (t) 3049 4444

INSIDE THIS ISSUE:

Classified Advertisement

Doctor Wanted to Work Full or Part-time Hours for GP-Owned Medical Centre in Sandgate.

ATTRACTIVE PACKAGE.

For more information apply to Dr Geoff Harding at Email: drgeoffh@bigpond.net.au

September-November 16

Narangba Family Medical Practice

Job Vacancy

A full time or part time Family Doctor for the Narangba Family Medical Practice (www.narangba-medical.com.au) as one of our doctors 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.

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**

Medicine ON SECOND

Job Advert VR GP Maroochydore

FEMALE OR MALE VR GP REQUIRED FOR A BUSY , GP OWNED MEDICAL CENTRE

We are a well established, spacious and modern medical centre , with a great team of fun and friendly doctors, nursing and reception staff.

- We are open 8.00am to 6.00pm Mon- Fri, and Saturday mornings on a rotating roster
- Option to work full time or part time hours
- Fully equipped treatment room and private procedure rooms, with full time pathology on site.
- Doctor couple welcome to apply.

Contact Judy Fifield: judy@medicineonsecond.com.au

PLEASE SEE OUR WEBSITE FOR FURTHER INFORMATION.

WWW.MEDICINEONSECOND.COM.AU

Medicine ON SECOND

AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

AMAQ Conference in India, Revalidation and Soapbox

INTERESTING NUMBERS FROM THE RECENT AMAQ CONFERENCE IN INDIA.
The population of India is 1.2 B = 60 times the population of Australia (in about half the land area). The population is growing at 1.8% pa, the annual increase equals the population of Australia. India's population will be larger than China's by 2028, 2B by 2040.

An oddity: a family planning programme from 1976 offered a free transistor radio for men presenting for vasectomy. Beggars presented for vasectomy for the free radio (without understanding what they were giving up), sold the radio on the black market, and could not understand why they could not present for a second time. Over 19M radios were given away, so many that the retail sales fell off and the retail distributor company went out of business.

Average life expectancy in India is 66 years (Australia is in the low 80's). The biggest single contribution is high infant mortality rate, and I think we were told that it is 30 times the Australian rate. Despite the national population density, 80% of the population are rural, most travel more than 20km to the nearest village for primary healthcare (not necessarily a doctor as we understand it). 50M have to travel over 100km to reach primary care.

GPI (gross personal income) is AUD 5,350 pa (Australia's GPI is about $60K). There are only 0.7 doctors per 1000 (Aus = 3.3). There are 1.2 nurses per 1000 population (UN recommends minimum 2.5). A typical GP consultation is 2-5 minutes, but there are sometimes 2-3 consultations simultaneously. GP's hours of work often extend to midnight.

India needs 550 new medical schools to achieve the global average number of doctors. All of our speakers denied that the brain drain of Indian medical graduates was a significant problem, but none had the numbers. However, we were told that healthcare workers working overseas are a significant source of foreign exchange, although this is probably more nurses than doctors and more from exports to other developing or third-world economies rather than from doctors emigrating to wealthier lands.

Many doctors expand their incomes by creating private family-operated "nursing homes" = day surgery clinics, not geriatric aged care, typically 20 beds. Typically the husband is a surgeon, the wife is an obstetrician. Public health budget is only 1% of GDP (least of all OECD economies, Aus = 9%, US probably 16%).

Average health expenditure is $75 pp pa (lowest of all OECD; Aus = $6K = almost highest of OECD), 33% is public funding, 87% is out of pocket. About 30% have basic health insurance. This is one of the world's highest out-of pocket spending rates. 40M families fall below poverty line each year trying to meet health costs. The healthcare sector growth is 16% pa. The health sector employs 5M people. 70% of new beds are in the private sector.

There is virtually no programmed aged care, virtually no nursing homes as we know them (or maybe none). There are a few geriatric respite centres styled as private aged-care resorts and very expensive, staffed by personnel trained in health care but not specifically in aged care, and not near the aged care standards known elsewhere in the Western world.

Telemedicine is being used to offset lags in physical and human infrastructure. It is more accessible than face-to-face healthcare. Even in shanty towns, locals watch Bollywood on (very cheap) smart phones. India is not particularly smart at technical innovation, but has a real talent for marketing and application of existing technology to new applications.

Indian generic drug makers now account for 40% of world generics. They have a large capacity for drug manufacture (they are the largest exporter to USA, double China's pharmaceutical exports).

Medical tourism is a major growth industry. Most patients come from elsewhere in Asia. The standards appear to be comparable with Western standards but prices are competitive with prices elsewhere in Asia. Don't ask me about guarantees or legal liability, but my guess is that a bad

Continued on Page 8

AUSTRALIAN MEDICAL ASSOC PRESIDENT
DR CHRIS ZAPPALA

AUSTRALIA NOW NEEDS LESS MEDICAL STUDENTS. YES OR NO?

Dear Members,

For the first time in history domestic medical graduates are faced with the real prospect of not being able to find a job, including for their intern year. This may not be so apparent in Queensland at present, but it is a real problem in southern states. The Australian Institute of Health and Welfare (AIHW) projects that there will be an oversupply of 5,000 doctors in 2020, and I suspect this is under-estimated. The prospect of organising vocational training for all these graduates is daunting and as, we are currently finding, not really feasible. Australia is now becoming saturated with doctors, as emphasised by recent workforce data.

A 2015 study by the Organisation for Economic Co-operation and Development (OECD) showed that Australia has the highest medical graduate rate per capita with 3.4 per thousand, compared to New Zealand and the United Kingdom (2.8 per thousand) and to the United States and Canada (2.6 per thousand), with Australian medical graduate numbers more than doubling in the past decade. 102,805 medical practitioners were registered in Australia in 2015. This compares to 79,653 employed in medicine in 2012. Health Workforce Australia estimated our doctor to patient ratio has increased to 3.6 per thousand, which is well above the OECD average of 3.2 per thousand and well above the UK (2.8 per thousand) and USA (2.5 per thousand).

I know some of you will try to take some refuge in the fact total numbers of doctors includes those who work part-time. When one considered full-time equivalent, the growth in general practitioner numbers has still kept pace with population growth, but growth in specialist full-time equivalents (FTEs) has significantly out-stripped it. In addition, graduating numbers of doctors is predicted to rise further as Notre Dame University (WA) comes online and larger first year cohorts of students move through to graduation. Workforce problems are only going to get more pressing and difficult to manage. Unemployment looms...

Post-graduate training opportunities have grown by 2.5 times in the last 15 years or so, but there remain real challenges in resourcing vocational training opportunities for registrars such that this will remain a bottleneck that will only become more problematic as graduating numbers increase. In this environment it is clearly imperative that medical student and vocational training numbers should reflect credible workforce data and not be driven by political/institutional desires or parochial interests.

Why therefore is Griffith University determined to have the Commonwealth Government fund 15 extra medical student places on the Sunshine Coast?

It is important we separate the issue of the extra medical student places from the obvious virtue of having a vibrant clinical/medical school operating on the Sunshine Coast. The AMA has always been in favour of this.

Griffith University leapt on the 35 medical student places relinquished by the University of Queensland when they decided to discontinue the Sunshine Coast clinical school. Having done this, Griffith University then realises that they want more - in addition to their current allotment on the Gold Coast. Universities have no obligations to the profession or even to their graduating students – they just want to make money with their courses and have the prestige of a medical school within their faculty. Griffith University divined 50 medical students to be the minimum viable number for a medical school. What is this based on? Why not continue to operate the campus as a clinical school like the University of Queensland did?

If we accept Griffith University's assertion of 15 extra medical students being required, there is absolutely nothing to stop them from negotiating release of these positions from another University, rather than requesting the Commonwealth to generate new positions. This is how they got the initial 35 to begin with! Of course this is harder and they would likely have to pay something for it. Negotiating funded places transfer is however still infinitely better for the profession than having to accommodate 15 extra graduating doctors every year in Queensland. It worries me that we've lost

Continued on Page 7

sight of the employment prospects for medical graduates generally (not just locally). The Universities like the thought of their graduates getting jobs but this is unashamedly not their primary concern. They are not concerned at the prospect of their graduates obtaining vocational training. They are not concerned about the profession's ability to mentor and train the extra junior doctors as residents. All University wants to do is fill seats. They're not worried about doctors or the profession – this is our concern. I accept this is how Universities operate – they are a business selling education. Therefore, we definitely should not let them dictate workforce outcomes for the profession.

Quite apart from the workforce data which is compelling enough on its own, I cannot imagine the Sunshine Coast ever have trouble in recruiting doctors to the area. Medical students still tell me Nambour Hospital is always over-subscribed for the intern year – and this does not include interstate migration. You simply do not need a local medical school to provide a workforce on your doorstep – that has never been how medicine has worked. In addition, there are other ways to promote research and education including joint University/HHS appointments, research funds, streamlined ethics processes, clinical titles and so on.

I know the AMA and Sunshine Coast LMA have been at odds on this issue. I hope the above article assists doctors in understanding the grave looming workforce problems we have and the national perspective that has led the AMA to the view that we oppose extra medical student places anywhere – not just on the Sunshine Coast. Our Western Australian colleagues have no idea how they are going to train and accommodate the new students with the recently announced Notre Dame University – let's not repeat the same mistake in Queensland.

Sincerely,

Dr Chris Zappala
AMA Queensland President

outcome won't get a good response under Indian liability.

After the food shortages of the 1960's, the fastest-growing disease profile is obesity and obesity-related diseases. Trauma is high (esp road traffic trauma), suicide rising rapidly especially in rural areas.

Austrade sees clear commercial opportunities – health intelligence, training (especially post-graduate and nursing), India lists high in biotech and offers cheaper R&D (Aus is strong on innovation but performs poorly on commercializing developments, India is strong on delivering affordable development), senior health is a nascent sector poorly serviced by Western standards.

India offers specialist training opportunities for Australian post-graduates. The example explored at the conference was knee arthroscopy. An undergraduate needs to perform at least 150 scopes to claim minimal expertise. Most orthopaedic trainees do not perform that number of scopes, because we do not have sufficient patients in an environment to be operated on by a trainee. A trainee could work in India and perform that number of scopes in a week. Procedural specialist trainees can spend a relatively short time in India to complete large numbers of procedures at a time when the same trainee would struggle to complete their logbooks in 5 years of training at home.

REVALIDATION

Ref Medical Board of Australia "Expert Advisory Group on revalidation. Interim report" August 2016. It is in interesting that the Board chose the term "revalidation" rather than "re-certification". Dr Joanna Flynn (Chair of the Board) always says that a first purpose of the medical board is to support doctors, but her talks are always about the second purpose, to protect patients.

Comments from the audience:
"Another bureaucratic intervention with no scientific basis and no apparent benefit to patients?" "The only possible benefit is as a dementia screening tool." What is the problem? The problem is probably that the profession, the Colleges, are not sufficiently self-regulating. If we fail to self-regulate, regulation will be foisted on us. Where is the evidence? It is known that 1% of doctors account for 25% of complaints. There is a case for re-credentialing of a problem sub-population. But even though re-accreditation has been increasingly adopted in other countries, there is no hard evidence that it makes a difference to adverse outcomes or complaints. The supposed increased safety for patients remains as yet unproven.

The Medical Board of Queensland is chaired by a midwife, and has a minority of members who are doctors. Six senior doctors have resigned from the Board in past year out of frustration. Applicants to fill the vacancies, and those recommended by AMAQ, were not accepted. There is a serious question about the integrity and validity of the Medical Board of Queensland.

In UK, the experience was that many older doctors retired prematurely when revalidation was introduced, a massive loss of knowledge and experience from the profession. AHPRA website opens by informing readers how to lodge a complaint, which raises a question about bias on the part of AHPRA. The mass of numbers of complaints is a fund-raiser for the agency. Managing complaints is a major time-consumer for administrators. Only a tiny proportion of complaints result in disciplinary action.

Visit the AHPRA website and make a comment.

At the meeting, there was no discussion about cost. Re-accreditation, or re-examination, will involve two costs (a) opportunity cost as doctors study instead of earning income, and (b) the actual cost of re-examination, which won't come cheap (maybe half the cost of a College final exam, your guess is as good as mine, plus costs of travel to an examination centre if you are regional).

The public will argue that this is a cost to be borne by the profession, if it is a pre-requisite to earning our professional incomes. The profession will argue that the cost is intended to protect the public so the public should pay, presumably as a slightly increased government rebate to factor in a few weeks of study leave every year. No prizes for guessing which argument will win – he who pays the piper will call the tune.

SOAPBOX

On the last day of the AMAQ conference in India in September,

Continued on Page 9

participants had the opportunity to have 5 minutes on a public soapbox to discuss their preferred topic, with 5 minutes Q & A to follow.

An underlying theme was that best outcomes will be achieved if we have medical leadership, doctors heading the policy bodies and executive bodies that govern the profession.

Medical marijuana. Now authorized by Federal & State governments – but with high levels of regulation under limited specified criteria. Canada has 2 years experience, "a nightmare" for GP's and promises to get worse. Controversial and divisive in the profession.

Medical certificates. Every medical certificate is a cheque on somebody's account. A doctor who signs the certificate has to exercise due care and accept responsibility.

Locums to remote places. An interesting mode of practice.

Loving the unloveable. I got to discuss strategies to encourage GP's to accept, if not welcome, marginalized and unpopular patients.

OFB. Aus is unusual in having a national screening programme, but world data is based on 2-year screening while our national programme is 5-year plan. Compliance is about 60%. The essence is "screening" ie it is intended for asymptomatic low-risk population. High-risk or symptomatic patients are investigated, not "screened".

80 years of medicine. 80th anniversary of UQ Medical school conducted recently (there were 22 graduates in the first cohort photo 1940). Remarkable how many family connections persisted in subsequent graduating years.

Recertification. See separate report.

New code of conduct for medical graduates in Singapore. C of C's need to be living documents reviewed periodically to accommodate a changing world. Social media especially are changing patterns of behaviour and Singapore has regulated professional relationships on social media. [Note that AHPRA and Medical Board of Australia have a guideline on social media practice. There is a special emphasis on not publishing testimonials.]

Psychiatric services – prevention and treatment. If services are managed by social workers, funding ends up being spent on soft services such as social care. Patients with best health outcomes are those who have choices in life.

Medical assistance in dying – a Canadian experience. Assisted suicide legislation has been enacted, with criteria that are not as clearly defined as we would like (eg a "competent" patient). Needs second opinion, no financial connection, 10-day cooling-off period. Practitioners feel uncomfortable in this role. Nurses are allowed to set up the infusion! [Gasp of horror from the audience.] The caution: this is a train rushing down the tracks towards Australian doctors, we need to be proactive so that lawyers do not dictate the rules.

Change in health insurance in Australia. For the first time in years, we have seen a fall in numbers of insured patients from 47.6% to 47.2%. Patients are losing faith in the private health insurance market. Increasing "junk" policies with multiple and unclear exclusions, difficult fine print.

Devaluation in policies because private hospitals chasing business, directing referrals, forming alliances with selected specialists, with high out of pocket costs. Changing from fee-for-service to fee-for-outcome service and increasing audits by insurers.

Patients want bundled fees, with no gap (now 85%) or known gap (now 6.5%). Insurers becoming more interventional, eg "pre-approval", or requiring justification for extra hospital days or expensive medications (remember US-style managed care).

Administrators are starting to refer to complications as "errors" – the terminology has a clear direction, but doctors argue that this should not shape funding. The insurers' profit in the year March 2015 to March 2016 was $1.476B. Minister Ley has formed a committee to reform private health insurance.

Wayne Herdy.
Branch Councillor

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

AMAQ Conference In India

"Expanded Scope of Practice" is being pushed by Queensland Health in its public hospitals. This involves basically "role substitution" of doctors. Of note, the Chief Allied Health Office has an advisory committee who is exploring by physiotherapists, podiatrist and pharmacists the following medications:

- Prescription of S8 opiates by physiotherapist in Accident & Emergency Departments
- Prescription of osteoporosis medication in geriatric units
- And the initiation of anti-retroviral therapy in HIV patients by pharmacists.

Of interest, this advisory committee does not have a medical practitioner on it. Australia now has a large number of junior doctors, and these doctors are readily available in A & E departments, Geriatric units, and available to HIV patients. This 'role substitution' is not needed in Australia due to the increasing number of medical graduates.

I also question the prescription of S8 opiates, osteoporosis medication and antiretroviral therapy by any other allied health professional other than a trained medical graduate. With the increasing large group of medical places in universities in Australia, and the increasing number of young graduate doctors, this idea of "Expanded Scope of Practice" and "role substitution' has become outdated and un-necessary, as well as clearly fraught with unsafe prescribing by non-medical personnel. I personally do not support this endeavour of Queensland Health, and consider it potentially dangerous.

Other countries, for example India, have a different doctor patient ratio in its population, and expanded scope of practice and role substitution is encouraged.

However, at the recent AMAQ conference (pictorial on Page 9), one of the General Physicians in one of the government hospitals described a typical day in his outpatients' clinic. He is expected to see 120-200 patients in his clinic, between the hours of 8.30 am until often 10pm. The waiting room is standing room only by patients. Each patient consultation takes between 2-3 minutes.

Towards the end of the afternoon, 3 to 5 patients are taken in together into the consulting room for a group consultation. That is the only way that one doctor can get through his patient list for that day. Often, there will be complaints to the politicians if they are not seen by the doctor. Some patients turn up with letters from politicians demanding that they be seen.

We do not have this situation in Australia. Expanded Scope of Practice and role substitution in Australia is now outdated, and un-necessary.

Sincerely Kimberley Bondeson

Continued on Page 11

Dr Kimberley Bondeson, RDMA President's Report Continued from Page 1

interested to know, the reasons behind it was the impact that the English Band, "The Beatles" had in India. They had visited the country on numerous occasions, and were followers of Maharishi Mahesh Yogi.

In February 1968, the Beatles travelled to Rishikesh in Northern India to attend an advanced Transcendental Meditation (TM) training session at the ashram of Maharishi Mahesh Yogi, who they had first met in the London in 1967.

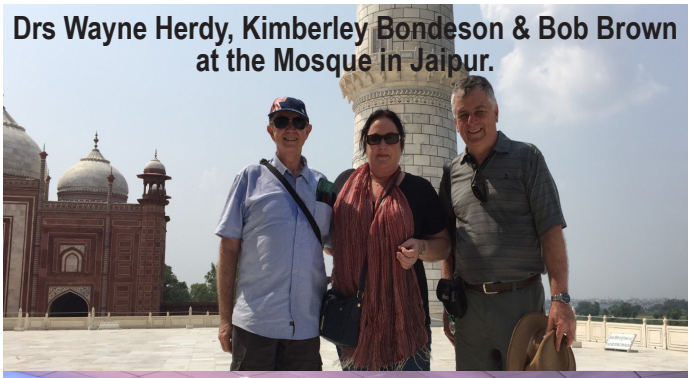
The Beatles became interested in India after reportedly using drugs in an effort to expand their consciousness (? LSD was in fashion in that time). While there, John Lennon, Paul McCartney and George Harrison wrote many songs, and Ringo Starr finished writing his first. Eighteen of those songs were recorded for The Beatles ('the White Album') and two songs appear on the Abbey Road Album.

Overall, India is a fascinating country, one of extremes, and very well worth visiting!

Kimberley Bondeson,
RDMA President

Continued on Page 11

The Indian Health MInister , Deputy Australian High Commissioner to India with AMAQ President Dr Chris Zappala



Drs Wayne Herdy, Kimberley Bondeson & Bob Brown at the Mosque in Jaipur.

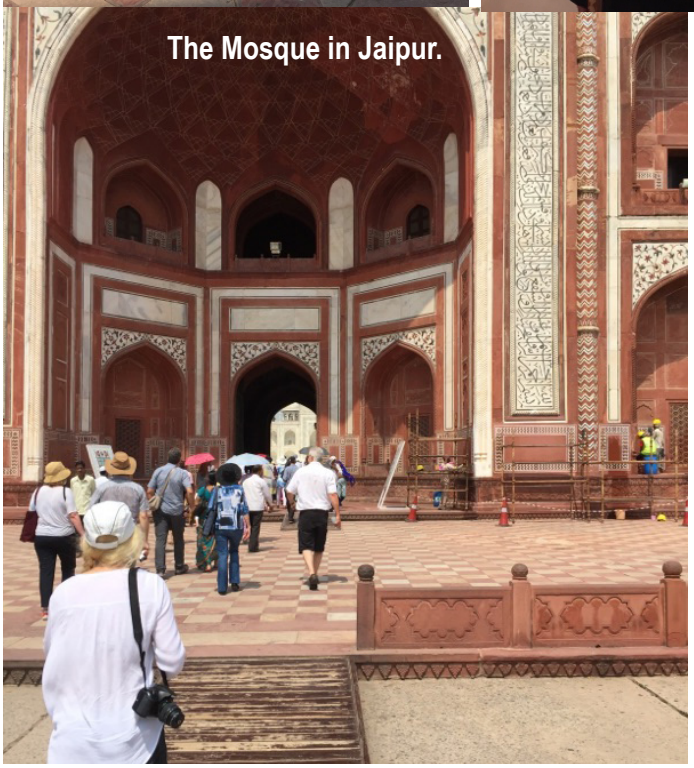
Colleen Sullivan, one of our guest speakers, and Dr Bob Brown and Carmel Brown, also dressed in traditional costume.

Peter Kemish, Dr Frank Anning and companion.

Taj Mahal in India.

Wayne Herdy in Costume at the Farewell Dinner at Jaipur

Kimberley and her husband, Peter Kemish, outside the hotel in Jaipur, India.



The Mosque in Jaipur.

Kimberley sitting on the “Princess Dianna”seat at the Taj Mahal, Agra in India.

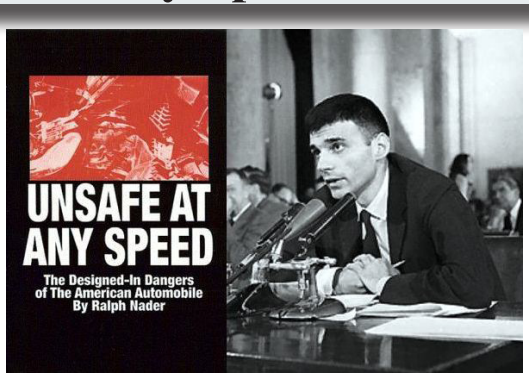
MEDICAL MOTORING

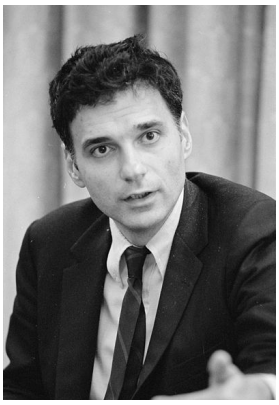
WITH DOCTOR CLIVE FRASER

Safe motoring,
doctorclivefraser@hotmail.com.

"Whistle-Blowers Are 'Unreasonable' People! Unsafe At Any Speed!"'

It's been just over 50 years since a young lawyer from Connecticut named Ralph Nader published a book about the American automotive industry titled, "Unsafe At Any Speed : The Designed-In Dangers of the American Automobile". Nader was the son of Lebanese immigrants and at the time was working (un-paid) for a Democratic Senator named Abe Ribicoff.





As a whistle-blower Nader should have been prepared for the retaliatory backlash from the politically conservative automotive giants because they would not be pleased by what he had to say in his book. In shades of Julian Assange and Wikileaks Nader was put under surveillance, his phone was tapped and prostitutes were hired by General Motors in an attempt to entrap the young man, apparently to no avail. At my age I have always thought that any young woman who showed an interest in me must be on someone else's payroll.

So why did General Motors go to such great lengths to discredit Nader? One would only have to start by reading the first chapter in his book which was titled, "The Sporty Corvair – The One-Car Accident".

This chapter featured a discussion of the safety and handling characteristics of the 1960 to 1963 rear-engined Chevrolet Corvair. It seems that the car was prone to dangerous over-steer because of its swing-axle configuration and the absence of $6 per car anti-sway stabilizers which were left out due to cost-cutting. General Motors had even ignored the advice of its own engineer (George Caramagna) that the anti-sway bars should come as standard, but they were offered as an option.

Chevrolet also recommended tyre pressures that were outside of the tyre manufacturer's specification meaning that the tyres were over-loaded. A subsequent 1972 review by the National Highway Safety and Traffic Administration did eventually find that the 1963 Corvair was "no less safe" than its contemporary rivals, the Ford Falcon and Plymouth Valiant.

But the rest of Nader's book was still on fire about hood ornaments which might seem to be designed to impale unsuspecting pedestrians, non-standardized gear shift selectors which could inadvertently send the car backwards, shiny chrome-plated and non-padded dashboards that dazzled drivers' eyes, and sharp knobs and switches that speared passengers.

And that's not to mention warranties that weren't honoured by manufacturers and the growing problem of automotive air pollution. Manufacturers were obsessed with styling and horsepower and didn't think that safety would sell. They believed that crashes were caused by bad drivers and bad driving.

The United States was falling way behind European manufacturers who were fitting radial-ply tyres and disc brakes which were actually saving people's lives.

Nader pointed out that Volvo could make a profit and sell cars with 3-point

CLASSIFIEDS remain FREE for current members & a maximum of 3 placements & not used as advertisements. To place a classified please email: RDMAnews@gmail.com with the details.

seatbelts. It really looked like Nader's book was going to be bad for business with the final chapter suggesting that, "the automotive industry should be forced by government to pay greater attention to safety in the face of mounting evidence about preventable death and injury". At the time about 1,000 people per week were being killed in US traffic crashes.

The US Government did eventually take notice and on 9th September 1966 The National Traffic and Motor Vehicle Safety Act was enacted to empower the federal government to set and administer new safety standards for motor vehicles and road traffic safety. In the 50 years since the US legislated safety standards automotive fatalities have reduced from 5.50 deaths per 100 million vehicle miles travelled to 1.07 fatalities per hundred million vehicle miles travelled? "Unsafe At Any Speed" would undoubtedly become a public health success story.

So whatever happened to Ralph Nader? His continued political activism has produced more legislation including the Freedom of Information Act, Foreign Corrupt Practices Act, Clean Water Act, Consumer Product Safety Act, and the Whistle-blower Protection Act

He has run for US president many times since 1972.

His presidential candidacy in 2000 may have unwittingly granted George W Bush the top job when Al Gore fell 537 votes short in Florida on a split liberal/democrat vote.

Nader has been affectionately described as "An Unreasonable Man".

According to George Bernard Shaw, "The reasonable man adapts himself to the world; the unreasonable one insists on trying to adapt the world to himself. Therefore all progress depends on the unreasonable man".

Safe motoring,
Doctor Clive Fraser
PS Ralph Nader catches public transport and does not own a car.

LETTER TO THE EDITOR
BY Dr Mal Mohanlal

Dear Editor

There was a report titled "6 things GPs should know about the new CPD" in the 6 Minute Medicine" published on the Internet on 10 October 2016.

Apparently all GPs have to complete mandatory "self-evaluation" from January 2017 for the next triennium. Here are my published comments on this issue:

"Why blame AHPRA? Isn't the RACGP responsible for this hairbrained scheme? This is the organisation which is supposed to look after GP interests.

All they do to justify their existence is to create more and more bureaucratic requirements for GPs to practice medicine. They do not know whether they are Arthur or Martha.

They believe in self-regulation as they are allowed to be chief cooks in the kitchen of the government prison camp.

Frankly, in my opinion if they were to disappear overnight no GP would miss them and general practice would be better off."

Did the RACGP consult the GPs about this scheme?

Are the GPs going to accept this without any objections or are they just going to take it lying down?

What about our AMA which is also supposed to look after our interests. Where do they stand on this issue?

My heart bleeds for the guileless medical profession which is being enslaved by our own colleagues who are supposed to fight for us, protect us and make our life easy.

Hippocrates where art thou?

Yours sincerely

MAL MOHANLAL

Warwick to Bathurst 30/09/16-9/10/16
Variety Bash 2016
Dusty Swags to Checquered Flags.

I have just completed the 2016 Variety Bash, and what an experience it was. And a learning curve. I'll talk about three domains

- the fundraising purpose
- the rally drive experience, and
- the social function of the Bash.

For those who haven't attended my previous communications, the Bash is a major fund-raising event for Variety Queensland, the children's charity. The money goes to supporting kids with special needs, their families and specific gifts are made to institutions. Variety has a venerable history arising when a child was left in a theatre to be cared for by actors read the website for more history.

The Bash started 30 years ago as Dick Smith persuaded his friends to drive cars at least 30 years old from Burke to Burketown, and it has run annually since, 27 years in Queensland. The fundraising purpose is pretty clear. What is not so clear is where the money goes. I was comfortable supporting this charity because it looked to me that most of the money goes to where it is actually supposed to go, which is more than you can say for most large charities. During this Bash, the fund donated a specialised trampoline to a school to allow disabled kids to enjoy the experience and maybe improve their motor function.

Individual support is more detailed, and I plan bringing to the LMA meeting a local family that has benefited from the support of Variety. Each family has a different function. To add a perspective and I hope it is not commercial in confidence, the top 10 fund-raisers in this Bash raised about a million dollars between them. The lowest fund-raisers had a minimum target of $8500 each, which we barely reached. Some teams spent the entire year in fund-raising, with sausage sizzles, raffles, golf days, and all very time-consuming slow ways of reaching the qualifying minimum.

The car rally experience was not what I had experienced in the past, but was a lot easier. This is a fun run, a drive in the country with mates. It is not a rally, so it is not competitive, not a speed trial. The navigation was also mostly straight-forward, the only real challenge being last-minute changes to the route caused by road closures after extensive flooding in central NSW. For an ex-rally driver/navigator, it was elementary, but for your average driver some of the mud sections through the forests were an extension of the comfort zone. There was a fairly challenging day of unpredictable and treacherous mud roads, but all cars and crews finally got in to a belated dinner.

What was different was the age of the cars involved, minimum 30 years old, needing a lot of care and attention as the days went by and old machinery showed its weak spots. Our car started chewing a LOT of oil, almost to the point of calling in at service stations to fill the oil and check the petrol. The engine will need some substantial rebuilding before the car sets off on its next adventure. There were a number of AWs, auxiliary workshops, which had entered as non-Bashers but in support of their friends in a Bash car, and the RAAF provided a mobile workshop which has surprising capabilities. During the Bash, a 1950s -something fire truck blew a clutch, and a VW beetle of similar vintage crunched its front end in both cases, a replacement part could be found reasonably locally and both vehicles were back on the road within a day.

The part that I was least prepared for was the mad antics of the social activity. From the moment we arrived at the starting point, it was clear that we had some very strange travelling companions. The cars had, in some cases, entered 10 or more Bashes and over the years a lot of work had been put into creating some quite bizarre vehicles. The photos tell only part of the story. The crews were even more entertaining. About half of the entrants were repeat entrants from past years, and played out their chosen characters day and night. One has to wonder if they all totally put their characters away in a box at home and become normal folk again until the next Bash. My favourite car was Mad Max and my favourite characters the Hippy Hornbags (from Maleny). We had clowns, two versions of Batman, Rocky Horror and the Simpsons, Men in Black and the Cat in the Hat, Captain Risky, and on it went.

The hardest to ignore were the Aussie Rock team, with VERY loud music blasting from the top of their car day and night. Of the 81 cars, half were old hands and had a polished act, the half of us who were newcomers were at first bewildered by the spectacle and eventually all just joined in the fun. By the end of the tour, we all knew one another, and it was clear why the past Bashers were greeting one another as old friends from day one. My team was entered as Old Bones (complete with skeleton costumes, although somehow that got translated to Old Farts which carried less of a medical message). Every day had a stop somewhere, usually pre-arranged to attract local attention and bring local kids in to get a touch of excitement and oodles of handouts from the Bash teams. Every small town where we stopped got an economic boost, an estimated $90K each stop spent on catering (service clubs, P&Cs), fuel, and alcohol which figured prominently in the social calendar from the outset (every car having a designated driver of course).

Would I do it again? Yes, but this time I would use the experience to create a better Bash for my team. I can see plenty of options to make it an opportunity for health promotion (Random Breast Test stops, when did you last have a mammogram? Prostate testing, don't worry fellas it's only a blood test. And perpetuating our Old Bones theme. Healthy young bones make healthy old bones an osteoporosis theme.) The Variety Bash next year will be departing from Caloundra in August and going out to Longreach. So the fundraising and the car preparation start all over again. See pictorial on page 20.

Wayne Herdy,

Continued on Page 20

MONTSERRAT
— CANCER CARE —

Excellence in Cancer Care Across South East Queensland

Our clinics are built with patient outcomes, comfort and atmosphere in mind. Our Day Spa environment makes people feel welcome, calm and nurtured. The manner in which we care for them eases the experience and provides a high level of dignity and excellence that all people deserve.

Providing treatment for blood disorders and cancer:

- Chemotherapy
- Iron Infusions
- Bisphosphonate Infusions
- Supportive intravenous therapy
- Blood Transfusions
- Blood product support
- Patient education and support
- Supportive Allied health services Dietician, Exercise and Massage

Meet Our Team

Dr John Reardon
Medical Oncologist/
Clinical Haematologist
***SC**

Dr Hong Shue
Medical Oncologist
***SC**

Dr Sorab Shavaksha
Clinical Haematologist
***SC**

Jesse Goldfinch
Excercise Physiologist
***SC**

Dr Rosanne Middleton
Clinical Health Psychologist
***SC**

Dr Peter Davidson
Consultant Haematologist
***NL**

Dr Kieron Bigby
Medical Oncologist
***NL**

Sarah Higgins
Dietician/ Nutritionist
***SC**

Dr Darshit Thaker
Medical Oncologist
Palliative Medicine Specialist
***NL**

Dr Lydia Pitcher
Haematologist/ Oncologist
Paediatric Haematologist
***SC**

Tania Shaw
Oncology Massage Therapist
***SC**

Dr Raluca Fieser
Clinical and Laboratory Haematologist
***NL**

Dr Geoff Hawson
Medical Oncologist
Clinical Haematologist
Palliative Care Physician
***NL**

Be Our Guest

Sunshine Coast Haematology and Oncology Clinic is delighted to be supported by the McGrath Foundation through the provision of the McGrath Breast Care Nurse, who is available to help community members and their families through breast cancer by providing free advice, support and care when it's needed most.

North Lakes Haematology & Oncology Clinic
Tel: (07) 3833 6755 | www.nlhoc.com.au
7 Endeavour Bvd, North Lakes Q 4509 (next to OzCare)

Sunshine Coast Haematology and Oncology Clinic
Ph: 07 5479 0000 | www.schoc.com.au
10 King Street, Buderim, 4556

Kyoto, The Bed of Cherry Blossums

By Cheryl Ryan

Kyoto is where you can celebrate the breath-taking symbol of spring – “sakura” or cherry blossoms. Fall in love with this season like the Japanese by enjoying the stunning view of the city of Kyoto coyly blushing as it gets hugged by a blanket of rosy cherry blossoms. You could partake in tea ceremonies at cherry blossom locations, or head to the countryside or the city and pick your own picnic spot under a cherry tree surrounded by beautiful pinkish-white blossoms. Whatever your style of enjoying this nature’s wonder is, you will never forget your first cherry blossom viewing season.

Kyoto’s Rosy Charm
Kyoto offers plenty of daytime as well as night-time “Hanami” or cherry blossom viewing locations.

- Nijo Castle: this historical castle looks all the more mesmerizing with 430 cherry trees decked up with pretty pinkish blossoms in the stunningly lit backdrop. Shopping for traditional Japanese apparel is also arranged for at the Nijo Castle area.

- Sagano and Arashiyama Area: The Nakanoshima Park in this area at the foot of Kyoto’s western mountains is flocked by tourists and locals alike for hanami. Many blossoming cherry trees hang low along the river and the nearby area which is lit up in the evenings during the hanami season. Head to the Togetsukyo Bridge for a great view.

- Shirakawa Stream: this beautiful stream provides magical scenery with a splash of what looks like pink candy floss everywhere and, you might even catch a glimpse of geiko or maiko shuffling along the cobbled lanes. Visit the stream at night to witness its beauty amidst beautiful lighting.

- Ohara Village: the beautiful valley where the historically rich village of Ohara is located, with its attractive gardens, temples and scenic countryside walking trails is a delightful way to spend your day. Gaze at the magnificence of nature and take in the sheer splendour of the sakura season to your heart’s content.

- The enchanting Higashiyama area is home to the Zen temple Kodai-ji which was the first temple to have after-dusk illumination to let the sakura viewers enjoy the beauty of the season even at night.

- Ginkaku-ji temple area is located away from the crowd and noise of the other cherry blossom sites and is ideal for serene long walks and mindful exploration.

What have we planned for you?
A comprehensive itinerary has been prepared to seize all the opportunities to cherish the splendid cherry blossoms in Kyoto.

- Tea ceremony at Kan-o-chakai, the exquisite garden teahouse of Heian Shrine, along with enchanting performances and elegant ikebana on display

- Trip to the old village of Ohara which is renowned for its ancient temples and beautiful gardens with many old cherry trees. Overnight stay at Ohara no Sato, a traditional Japanese-style ryokan, on special demand

- Visit to the splendid Shoren-in Temple along with its 800-year old majestic cryptomeria trees and light-up display

- Trip to the Nijo Castle and the Castle-area shopping

- Trip to the Arashiyama Area for hanami

www.123Travelconferences.com.au

Planning Aged Care Needs

The wave of older Australians will continue to grow over the coming decades. As such, we can no longer afford to ignore the issues around aged care with over 1 million retirees already accessing aged care services in Australia.

Planning ahead can help to demystify aged care and reduce stress levels. With awareness and pre-planning retirees can maintain control and choice and have access to the financial resources to pay for care and minimise the stress on families. This brief article discusses the steps older Australians could consider when planning to move to residential aged care.

Assessing options

Aged care help can be accessed in a retirees home or in a residential service. They are able to arrange a free assessment by an Aged Care Assessment Team/Service (ACAT/ACAS).
They will need to have ACAT/ACAS approval before they can access a government subsidised home care package or residential care.

Tips – They can book an appointment directly with ACAT/ACAS on 1800 200 422. Further information is available at www.myagedcare.gov.au

Searching for services

Make a list. This should include location, amenities and specific health care needs. This list will help patients develop a shortlist of potential services that they may require. Also patients need to check what fees will be asked for accommodation and ongoing services to ensure it is affordable.

Tips - Search for services by visiting myagedcare.gov.au and search by postcode for the list of aged care facilities in their preferred location. Also search the internet for 'aged care placement services' for advice and help to choose a service and negotiate a place.

Structuring finances

Residents may be faced with accepting a place in whichever service has a low-means place available and could even be a shared room. Structuring assets to pay for accommodation as well as create sufficient cash flow is paramount.

Estate planning

Retiree's Wills should be reviewed and updated to reflect wishes. As dementia is a leading factor behind the need for care services, when the time comes it is likely that the client will need to delegate financial decisions to someone else. This is easier if an enduring power of attorney (and guardianship) is in place. So it is important to have the appropriate powers in place before a person has lost legal capacity as once capacity has been lost, it will be too late to set up the powers and a trip to the Guardianship Tribunal will be needed.

If you would like to discuss any questions you may have please give me a call.
Kirk Jarrott Partner – 07 54379900

The statistics

- On average, one new case of dementia occurs in Australia every 6 minutes
- 30% of people over age 85 have dementia
- More than 50% of people in subsidised aged care facilities have dementia

Source: Alzheimers' Australia, www.fightdementia.org.au

Australian Medical Association Limited
42 Macquarie Street, Barton ACT 2600:
PO Box 6090, Kingston ACT 2604
ABN 37 008 426 793
T: (02) 6270 5400 F (02) 6270 5499
Website : http://www.ama.com.au/
AMA

LEADING DOCTORS AND SCIENTISTS SPREAD THE WORD (AND THE EVIDENCE) ON THE BENEFITS OF IMMUNISATION

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Launch of Australian Academy of Science booklet – The Science of Immunisation: Questions and Answers

The AMA has joined forces with the Australian Academy of Science to promote and distribute the Academy's revised and updated booklet, The Science of Immunisation: Questions and Answers, an important resource to inform all Australians about the facts, evidence, and benefits of immunisation.

The booklet was launched today at Parliament House in Canberra by Health Minister, Sussan Ley; the President of the Australian Academy of Science, Professor Andrew Holmes; AMA President, Dr Michael Gannon; and Professor Peter Doherty, winner of the 1996 Nobel Prize in Physiology or Medicine for his work on immune cells.

Dr Gannon said it is vital that parents are provided with the most authoritative, scientifically-backed, clear, and easy-to-understand facts and evidence about the safety and effectiveness of immunisation.

"Having children vaccinated is a significant event for every family, and it is important that parents know all there is to know about vaccination, and the Academy's booklet answers all the questions and provides compelling evidence about the benefits to the health of the child," Dr Gannon said.

"The Academy's thorough scientific evidence and research, which has been provided by Australia's leading researchers in immunology, is the perfect response to the lies, misinformation, and fear that is peddled by the anti-vaccination movement.

"Immunisation saves lives. That is an undeniable fact.

"It is important that all Australians are provided with evidence of the health benefits of immunisation to help them make the right choices.

"It is the job of doctors to reassure patients when they present with fears or concerns about immunisation.

"This booklet will help educate the general public, public health services, schools, and the media about the benefits of immunisation."

Dr Gannon said that since the introduction of the Government's No Jab No Pay policy, 6000 children previously registered as conscientious objectors are now fully immunised, but more needs to be done.

"Unfortunately, there are still areas within our community - such as the Gold Coast, Western Sydney, and the North Coast of NSW - with lower than average immunisation rates," Dr Gannon said.

"These areas are highly susceptible to outbreaks of vaccine-preventable disease.

"The authority and clarity of the Academy's information about the safety and efficacy of immunisation will help get the message to parents in these key areas, and ensure that Australia's immunisation rates remain high.

"Vaccinations have brought great comfort and security to the health of the community and the Australian way of life.

"We need to be vigilant and provide the right information to keep it that way."

To date, 72,000 copies of The Science of Immunisation: Questions and Answers have been distributed to key locations, including doctors' surgeries, around Australia, with the assistance of the Commonwealth Department of Health and Ageing.

The booklet is available at https://www.science.org.au/learning/general-audience/science-booklets/science-immunisation

10 October 2016

CONTACT:
Kirsty Waterford 02 6270 5464/ 0427 209 75
John Flannery 02 6270 5477 / 0419 494 761

Follow the AMA, President, Australian Medicine on Twitter https://twitter.com @ama_media, @amapresident, @amaausmed, @AMAGenPractice

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION INC
MEMBERSHIP SUBSCRIPTION BENEFITS

ABN: 88 637 858 491

Notice to New and Past Members

Don't waste time! Join now!

CPD Points Certificate Available

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.

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 speakers are most welcome. Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost.

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: $120.00; Oct to June: $90.00; Jan to June; $60.00; April - June: $30.00)
2. Two Family Members ($20.00 Discount each) ($200 pro rata) (Please include each person's details)
3. Doctors in Training and Retired Doctors: FREE

1. Dr _____

(First Name) *(Surname)*

Email Address: _____

2. Dr _____

(First Name) *(Surname)*

Email Address: _____

Practice Address: *Postcode:* _____

Phone: *Fax:* _____

CBA BANK DETAILS: Redcliffe & District Medical Assoc Inc: BSB 064 122 AC: 0090 2422

1. PREFERRED PAYMENT METHOD: INTERNET BANKING

2. PAYMENT BY DEPOSIT SLIP: INCLUDE your name: ie: Dr F Bloggs, RDMA A/C and Date

3. ENCLOSED PAYMENT: (Subscription Form on website, type directly into it and email)

i) Complete Form and Return: C/- QML or RDMA at PO Box 23 Redcliffe 4020

2) Or Emailing to GJS2@Narangba-Medical.com.au

Variety Bash Rally with Dr Wayne Herdy

30/9-9/10/16 Continued from page 14