RDMA

REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter

SEPTEMBER 2011

Deception Bay

See Deception Bay and Surrounds featuring in our Historical Pictorial in this edition page 3, 6 and our regular Where We Live And Work segment Page 20

RDMA President's Message ... Dr Wayne Herdy

PRESIDENT'S REPORT

At the AGM last month, the meeting re-elected all four members of the old executive. This is a solid endorsement of the path that the Association has followed for the past year.

However, I am ambivalent about the outcome, because it also reflects a reluctance of members to stand up and be counted, to be prepared to serve on the committee. The LMA committee is not only a body to serve the Association, it is also a training ground for any who might aspire to serve a larger audience in the medico-political arena. Next year, we will be looking for more new faces on the management committee.

What direction will the Association be taking in the coming year?

We will be building on our strengths, but not resting on our laurels. Our emphasis will be on communications with members and non-members. Our Newsletter still needs some polishing, especially to make it financially stronger. As a communication tool, we plan widening its reach, especially ensuring that all trainee doctors in our hospitals receive copies, doctors who normally escape the outreach of professional organisations. Our website is running in summary form and will be expanded to a much richer environment for our members to explore.

And the lifeblood of all membership organisations is membership growth and retention. We will be looking to expand our membership, deciding what we can do to meet the needs of the hundreds of doctors in our geographic catchment area who presently do not see that we are giving them anything that justifies our rather modest annual subscription

The management committee is dedicated to the success of the Association. We need the input of you, our members, to continue and build on our past success.

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

QML Pathology. | Redcliffe Laboratory
Partnering with Redcliffe & District Medical Association for more than 30 years.

DATE CLAIMERS :

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

Venue: The Ox, 330 Oxley Ave, Margate

Time: 7.00 pm for 7.30 pm

2011 Dates:

DATE CHANGE

Wednesday September 21

Wednesday October 26

Year End Networking Function

Friday November 25

CONTACTS:

President: & AMAQ Councillor:	Dr Wayne Herdy Ph: 5476 0111
Vice President:	Dr Kimberley Bondeson Ph: 3284 9777
Secretary:	Dr Ken Fry Ph: 3359 7879
Treasurer:	Dr Peter Stephenson Ph: 3886 6889
Meetings' Convener:	Ms Margaret McPherson Ph: 3049 4429
MBGPN CEO:	Ph: 3284 5155
MBGPN Chair	Dr Wayne Herdy Ph; 5476 0111
Newsletter Editor:	Dr Wayne Herdy Ph: 5476 0111

For general enquiries and all editorial or advertising contributions and costs, please contact: RDMA Newsletter Publisher. Please email (preferred) any correspondence to:

Email: RDMAnews@gmail.com
Website: http//www.rdma.org.au
Mail: RDMA, PO Box 223, Redcliffe 4020
Fax: (07) 5429 8407
Mobile: 0408 714 984

OCTOBER NEWSLETTER 2011

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

Please email the RDMA Publisher at RDMAnews@gmail.com or Fax: (07) 5429 8407

Website: http//www.rdma.org.au

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Deception Bay Recreational Centre

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT

Dr Richard Kidd

The Latest News From AMAQ President

This month there has been a number of issues affecting members and Queensland patients including a new nurse practitioner-led clinic set to open in Brisbane in September.

I have been quite vocal on this issue stating clearly there is a role for nurse practitioners to play but they should always be working in collaboration with doctors in safe supported teams.

To become a GP requires at least 15 years of training to deal safely with undifferentiated presentations in patients. A stand alone nurse practitioner clinic does not give the nurse practitioner the safety and support of sharing a problem at any time with the patient's GP.

While these clinics may be convenient for patients, they don't aim to offer the same continuity of care that allows knowledge of a particular patient's medical history to be built up over time.

A thorough understanding of a patient's medical past is what often leads to an important diagnosis and stand alone nurse practitioner clinics threaten to disrupt that relationship. A clear example of this is the risk to immunisation rates falling due to this fragmentation of care.

Another issue that has caused concern amongst members over the last few months is the billing arrangements in rural and remote communities, in particular in Queensland Health hospitals.

Interest groups and I attended a Queensland Health stakeholder meeting to discuss this issue. While the meeting provided an excellent forum for stakeholders to relay their concerns about these arrangements I was very clear that this 'consultation process' should have occurred before these clinics were established, not after.

The GP Alliance, of which AMA Queensland is a member, is attempting to develop a more complete, evidence-based picture of these billing arrangements. Currently a survey is being prepared and will be distributed to all GP members in an attempt to collate as much information about these arrangements as possible.

I encourage all members to complete this survey once it has been distributed.

Over the past three years, the AMA Queensland Visiting Medical Officers (VMO) Committee, chaired by Dr Ross Cartmill, has been negotiating with Queensland Health in order to achieve a new agreement to replace the now long-expired previous agreement.

More recently, terms for an agreement have been negotiated between the parties and are now subject to whole of government approval.

In the meantime, the listing of this matter for hearing before the Queensland Industrial Relations Commission has been adjourned to allow the proposed terms of agreement between the parties to be either formally signed off by government or rejected and returned to the Commission for determination.

The presence of VMOs in the system is absolutely critical. AMA Queensland and the VMO Committee have worked very closely together to make every effort to see that VMOs are supported and encouraged to continue to provide their services within the public sector, particularly throughout rural and regional Queensland.

We are hopeful that we are close to reaching an agreement however in the meantime, if you have any queries please contact the Workplace Relations Department on (07) 3872 2207.

Dr Richard Kidd
AMA Queensland President

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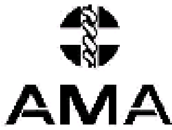


The Medical Journal of Australia
Established 1914 • Journal of the Australian Medical Association
eMJA

SHOULD MORE AUSTRALIAN DOCTORS BE SALARIED RATHER THAN PAID BY FEE-FOR-SERVICE?

EMBARGOED UNTIL 12 NOON SUNDAY, 4 SEPTEMBER 2011

Salaried doctors have no conflict of interest in the doctor-patient relationship, which engenders a patient's trust, and reduces anxiety for the practitioner, Dr Brian Peat, an obstetrician from the Women's and Children's Hospital, Adelaide, argues in the latest edition of the *Medical Journal of Australia*.

Dr Peat wrote that more doctors should be on salaries, saying that it would be simple to change the current balance of numbers between salaried doctors and fee-for-service doctors, and that salaried doctors have the advantage of lower administration costs.

"They are in a better position to consider all aspects of the patient's health, and to appropriately delegate tasks knowing they will not be out of pocket," Dr Peat said.

Dr Peat said that often lifestyle-related chronic illnesses don't fit into the short-consultation model for fee-for-service doctors, but salaried doctors can work around this issue.

"In a practice where patients with chronic illnesses are treated, a doctor may be required to take on the role of team leader, which is a difficult role to provide an item of service for. However, it is one well suited to a salary package."

But in an opposing view, Dr Douglas Travis, a urologist from Western Health, Melbourne, and a Past President of AMA Victoria, argues that the majority of doctors should continue to be paid by fee-for-service.

"From the perspective of doctors, patients and funders, fee-for-service is the best method of remuneration because it provides the best transparency, accountability and incentive for everyone," Dr Travis said.

"As a patient, you pay for what you get, and, as a doctor, you get paid for what you do.

Dr Travis said that there are a lot of misconceptions about fee-for-service payments, including that it encourages overservicing, results in people being unable to afford medical care, encourages doctors to try to provide more services in a given period, causes doctors to work excessive hours and offers no incentives to maintain continuing medical education.

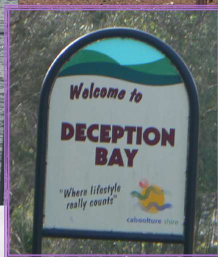
However, Dr Travis said the fee-for-service model was not appropriate in research and teaching settings.

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

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

CONTACT: Dr Brian Peat 0422 005 136
Dr Douglas Travis 0437 253 731

Deception Bay
Redcliffe Parkland & Recreation Enhancement Project



RDMA Patron: Dr Peter Marendy

RDMA ANNUAL GENERAL MEETING

Re-Elected Executive Officers

Left to right: Dr Ken Fry – Secretary, Dr Wayne Herdy – President, Dr Kimberley Bondeson – Vice President, Dr Peter Stephenson – Treasurer

Returning Officer: Glenn Sproles

New Member: Richard Buzacott

Allergan Sponsors: Richard Dennis, Lara Jacobs and Presenter: Dr Blair Bowden

Tracey Blackmur, Meeting Convener

The RDMA Annual General Meeting held on the 31/08/11 was presided over by Dr Wayne Herdy, RDMA's President. The outgoing executive team was announced by Glenn Sproles who was the Returning Officer. The income executive team was Wayne Herdy - President, Kimberley Bondeson - Vice President, Peter Stephenson - Treasurer and Ken Fry - Secretary. The AGM's Sponsor was Allergan whose representative Richard Dennis and Lara Jacobs introduced the night's presenter Dr Blair Bowden. The topic of the night was Lap-Band, Gastric Bypass, Sleeve Gastrectomy and Gastric Balloon... Fat, Fiction or Folly.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: Wednesday 21st September 2011

Time: 7 for 7.30pm

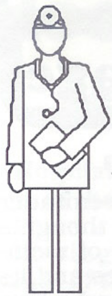
Venue: Renoir Room - The Ox, 330 Oxley Ave, Margate

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

Agenda:

7.00pm	Arrival and Registration
7.30pm	Be seated - Entrée served Welcome by Dr Wayne Herdy - President RDMA Inc.
7.35pm	Sponsor: Novartis Pharmaceuticals
7.40pm	Speaker: Dr Andrew Smith Topic: Diseases of the eye and the diabetic patient
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: Margaret.MacPherson@qml.com.au
t: 3049 4429 by Friday 16th September



REDAMA Report

Official publication of the Redcliffe and Districts Local Medical Association

Issue No 6
September, 1989
Free to the Medical Profession

Questionable rebate system is about to become reality

The highly questionable two-tiered Medicare rebates system is now only a step away from reality, following its adoption, without change, by the Senate Selection Committee on vocational registration of general practitioners.

Federal Health Minister, Neal Blewett, dealt the medical profession a body blow when he announced late in August that he could see no reason to delay implementation of the new fee arrangements.

Protests by the Australian Medical Association and diverse branches of the medical profession failed to convince the committee or the Government that the system would not be in the interests of doctors or their patients.

Under the new system, doctors who qualify and enroll on the "central register" of GPs will be entitled to use a new set of item numbers which will allow the patient to qualify for a higher rebate.

To qualify for the "Central Register of Medical Practitioners" (or CROMP for short), doctors must undergo "specified" training.

Billing will be on the basis of "complexity" of the type of service and rebates will reflect the level of billing by the doctor.

Doctors who do not qualify, or who decide not to enroll, will work on existing item numbers and their patients will receive only a lower Medicare rebate.

Dr Blewett has since been quoted by a Health De-part-ment spokesman as saying that all practitioners will receive a 5 per cent fee increase.

The AMA's opposition to the plan has been based on the serious effect it is likely to have on young doctors, women doctors and other small, specialised groups of practitioners.

At the Redcliffe LMA, which has been at the forefront of militant action against the proposal, Dr Ralph Smallhorn has called for doctors to refuse to register with CROMP.

"If we do register, it will be like leading lambs to the slaughter because we will be playing into the hands of the Government's plan for nationalised medicine," he told a recent meeting of the branch.

However, Federal AMA president, Dr Bryce Phillips has now pledged that the association will respond positively to proposals "for its further involvement in implementing the general thrust of the report."

The key issues in the Select Committee's findings are contained in a precise statement issued by the chairperson, Senator Rosemary Crowley.

This is a summary of the report:

'For many years, general practice and its practitioners have had to struggle for fair recognition within the medical world.

Despite the fact that general practice is the first port of call for the majority of people seeking medical care and assistance, it has long been

Continued Page 4

Janssen -Cilag had the honour of sponsoring the first dinner meeting under new president, Dr Kerry Garske.

With a change of room at the Golden Ox, to make way for a 21st birthday in the usual venue, the meeting had a more intimate atmosphere.

Dr Garske greeted Janssen Cilag's Queensland Field Manager, Jayne Kyle-Little, and guest speaker, Dr Graham Solley, before the meeting and inspected the display stand of a number of samples of the company's products.

Dr Solley later kept his audience fascinated as he fielded dozens of questions on allergies, ranging from insect stings to exercise.

AMAQ & FEDERAL COUNCILLOR REPORT

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

Wayne Herdy

What about the PCSEHR?

The patient-controlled shared electronic health record still needs a lot of work.

The big stumbling block at present is the "patient-controlled" bit. We have only little hesitation in allowing patients to choose who has access to the record – that is patient control to access.

We do have major hesitations about allowing patients to control the content of the record.

If patients can add to, delete from, and generally amend the health record, doctors will not use it.

We will not add valuable clinical material if we believe that the patient might change it.

We do not want patients adding clinical material that might be precious to the patient but of no value to a mainstream clinician.

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Australian Medical Association Limited
ABN 37 008 426 793

42 Macquarie Street, Barton ACT 2600: PO Box 6090, Kingston ACT 2604
Telephone: (02) 6270 5400 Facsimile (02) 6270 5499
Website : http://www.ama.com.au/

MEDICAL ADVICE MISSING FROM E-HEALTH RECORDS PLAN

AMA President, Dr Steve Hambleton, said today that the AMA was disappointed that the Government has failed to heed medical advice in finalising its Concept of Operations for the personally controlled electronic health record (PCEHR).

Dr Hambleton said the proposals could 'de-medicalise' electronic patient health information.

"Little has changed from the draft plan despite the sound advice provided by many medical groups, including the AMA, about what should be included on a patient's health record.

"The Government has caved in to minority consumer groups.

"Under the proposed arrangements, people will be able to alter their health record without consultation with their doctor.

"Patients could entirely remove from their record clinical documents that they had previously considered worth sharing with healthcare providers.

"This is a very dangerous precedent that could undermine all the potential benefits of an electronic health record."

Dr Hambleton said that the AMA would prefer the system to be opt-out, not opt-in.

"The opt-in system has resulted in incredibly complex rules for patients to give their doctors access to their PCEHR," Dr Hambleton said.

"And there are still concerns around medico-legal liability associated with the electronic health record.

"The AMA is a huge supporter of e-health and the benefits it can bring to the health system, but we cannot support aspects of the system that do not improve on what we have now and which potentially create risks to patient health.

"We will have a system that doctors and other health practitioners are keen to embrace but won't be able to because their patients haven't yet given them access to their records.

"Australia has the opportunity to be a world leader in electronic health but it won't happen with the very complex health record announced today," Dr Hambleton said.

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12 September 2011

CONTACT: John Flannery 02 6270 5477 / 0419 494 761
Geraldine Kurukchi 02 6270 5467 / 0427 209 753

From Page 1

Rebate system nears reality

the view that general practice is the Cinderella of medicine - not quite up to the level of its specialist sisters.

This proposal ensures that that view will no longer prevail.

It gives recognition to general practice as a significant and separate area of medicine and acknowledges the efforts of general practitioners to improve their practice through vocational training at the post graduate level.

Despite the considerable agreement within the profession for recognition of general practice, and the need for vocational training, the agreement between the RACGP and the Government precipitated a major debate within the profession and opposition to the legislation which has been referred to this committee.

The proposed vocational register will be no more than an additional notation on a pre-existing list of medical practitioners, indicating eligibility to use certain new item numbers on the medicare Benefits Schedule, which will only be available to vocationally registered general practitioners.

As such, the register is similar to the existing register of specialist medical practitioners, maintained by the Health Insurance Commission.

The HIC already keep a Medicare Provider File (MPF).

The General Manager of the HIC must act in accordance with either a certificate provided by the RACGP or regulations made for the purpose.

Issuing such a certificate is a proper role for the RACGP.

The Committee notes that the power to make regulations under this proposal has been an area of particular concern to many medical practitioners.

Thus, to put the meaning of the regulations beyond dispute, and to acknowledge the concern expressed to the Committee regarding difficulties of registration for other than FRACGP holders, the committee recommends that:

A committee, or committees as required, to be called the Vocational Registration Eligibility Committee (VREC) be established by regulation, to be responsible for the certification of those primary care medical practitioners who do not apply through the RACGP or whose applications have been referred to the VREC by the RACGP or whose applications are rejected by the RACGP.

A committee, to be called the Vocational Registration Appeals Committee (VRAC), be established by regulation to hear appeals both for medical practitioners who are refused certification and for medical practitioners whose removal from the register has been sought under Section 3G.

For each of the Vocational committees, the RACGP, AMA, Australian Medical Council and the National Specialist Qualification Advisory Committee will be invited to nominate a panel of three medical practitioners for selection by the Minister.

The Minister will select one person from each panel and he will nominate a fifth member who is suitably qualified and experienced.

A similar system will be used to select the VRAC members and a member of VREC will not be eligible for membership of VRAC and vice-versa.

The committee concludes that vocational training is highly desirable prior to entering into unsupervised general practice and that such training should be formal and supervised.

The RACGP was nominated as the body to accredit vocational training courses for general practice for the purpose of registration.

In accordance with the recommendations of the Doherty Report, vocational training is not to be mandatory, and financial incentives should be provided to encourage medical graduates to undertake vocational training.

The Committee recommended

• Accreditation of courses and the setting of standards in general practice by the responsibility of the RACGP;

• The criteria established by the RACGP for eligibility for vocational registration of general practitioners be published and widely circulated;

• The RACGP ensure that medical schools and student bodies will be provided with information about eligibility criteria to inform their undergraduates.

The committee recommended that the RACGP, after negotiation with other professional organisations, should produce clear guidelines for credit towards vocational registration that will be offered for study and experience gained outside the new FMP.

It also recommended that in addition to the options for vocational registration, discussions should be initiated by the Department of Community Services and Health with the RACGP and bodies representing practitioners in primary care special interest areas, to consider parallel arrangements for vocational training (CME) quality assurance and evaluations and descriptors suitable to their type of practice.

The Committee also stressed that where an area of practice clearly falls outside the definition of general practice, the RACGP will assist those areas to develop "appropriate" content based descriptors, CME and quality assurance programmes.

It endorsed the recommendation of the Doherty Report that said specialist medical colleges and associations, including the RACGP and Family Medicine Programme should take note of the changes proposed in the second pre-registration year, including community experience, and incorporate them into their training programmes, without increasing the length of time to complete vocational training.

The Senate Committee recommends that trainees not be eligible for vocational registration and the case for providing registration at some stage during training should be considered further by the RACGP and the Department.

In acknowledging there had been criticism of the anomalies created by the introduction of the new arrangements up to 1995, the committee recommended that the RACGP examine all alleged anomalies and provide a balanced and equitable range of acceptable experience.

The Committee recommended that the Health Department examine the relationship between general practice and hospitals, both metropolitan and rural.

A key recommendation was that the proposed Independent Peer Review Organisation not proceed.

This was tempered with the rider that the committee recognised the importance of the new descriptors being properly monitored and evaluated.

On this point, it recommended that a Descriptor Utilisation Review Committee be established and that the review process be the responsibility of vocationally registered general practitioners chosen by their peers and not operating within their own region.

A tripartite working party, comprising representatives of the Department, the RACGP and the AMA was recommended to develop and finalise the proposal for descriptor utilisation review.

And audit procedures to examine practices for fraud and over-servicing continue to be the function of the Health Insurance Commission.

The committee recognised that the FMP requires continuing scrutiny and evaluation, but believes this does not reflect any weakness in the programme.

Rather, it reflects the need to reconcile the maintenance of overall standards and training objectives with the deliberate policy of having a decentralised and flexible programme where individual content is largely determined by the trainee, the committee said.

It "noted" that where problems exist with the FMP, the "RACGP is aware of them and is acting effectively to rectify them."

Other recommendations were:

• An essential component of the whole proposal must be the provision of adequate funding to ensure there are sufficient places available for those wishing to take part in the FMP;

• The RACGP examine the content and structure of the FMP with a view to providing options with regard to the length and intensity of the course to accommodate different training requirements while maintaining "appropriate" standards:

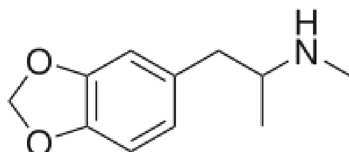
Continued Page 6

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #85

Rolls Royce Silver Seraph
"The Spirit of Ecstasy!"

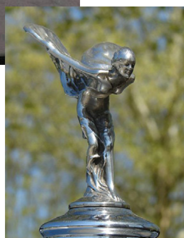
21st Century party-goers know that Ecstasy is a potent stimulant which induces a state of euphoria and a sense of intimacy with others.



In a recent disturbing trend the pharmacologists amongst "E" users have now worked out that taking moclobemide (Aurorix) with their MDMA gives them an even greater hit.

As an inhibitor of monoamine oxidase A, moclobemide reduces the oxidation of 3,4-Methylenedioxymethamphetamine and increases the likelihood of death either by cardiac arrhythmia or hyperthermia which leads to organ failure.

At a core temperature of 42 degrees Celsius the human body simply begins to cook and there is very little that intensivists can do to reverse that process.



I'm ashamed to admit that my youth was simply spent tinkering with cars (and motor-bikes) and that "ecstasy" had more to do with romance than psycho-pharmacology.

This year Rolls-Royce owners will be celebrating the centenary of the marque's decision to place a flying lady on the bonnet, the so-called "Spirit of Ecstasy".

In 1911 Charles Robinson Sykes was commissioned by John Walter Edward Douglas-Scott-Montagu , (Lord Montagu of Beaulieu) to design a radiator mascot for his Rolls-Royce.

The public weren't widely aware that the model for his mascot was M'lud's secretary, Ms Eleanor Velasco Thornton.

Whilst Victorian sensitivities would not have allowed Lord Montagu to have openly had a relationship with the lower-class Ms Thornton, he must have loved driving through the local village with a scantily-clad girl-friend adorning his bonnet.

Doctors who want to drive into the hospital car-park with their practice manager as their radiator mascot might like to take a closer look at the second-hand Rolls-Royce market.

For about the same price as a new Lexus GS460 you can pick up a low-kilometre 2001 Rolls-Royce Silver Seraph.

Back in its day it came with all the modern safety features we expect in a new car like air-bags, ABS and traction control and there was even real walnut on the dash-board.

The only problem for die-hard Brits is that the Silver Seraph was the Rolls-Royce made by Germany's Volkswagen.

And in a poetic twist of fate historians note that Lord Montagu's flying lady mistress was killed in 1915 when the ship that she had boarded was torpedoed and sunk by a German submarine.

2001 Rolls-Royce Silver Seraph

For: Patients might think you're a better doctor.
Against: Patients will expect to be bulk-billed.
This car would suit: Sir Lancelot Spratt.
Specifications:

5.4 litre 48 valve V12 PULP
240 kW power @ 5,000 rpm
490 Nm torque @ 3,900 rpm
5 speed automatic
13.5 l/100 km (combined)
$136,800 ($535,000 + ORC when new).

Dr Michael Cross says: "Clive, Rolls-Royce is the best car in the World. That's all you need to know!"

Safe motoring,
Doctor Clive Fraser
doctorclivefraser@hotmail.com

Interesting Tidbits NATTY MOMENTS:

ALL PUNS INTENDED

1. Two antennas met on a roof, fell in love and got married. The ceremony wasn't much, but the reception was excellent.

2. A set of jump leads walk into a bar. The bartender says, 'I'll serve you, but don't start anything.'

3. Two peanuts walk into a bar and one was a salted.

4. A dyslexic man walks into a bra.

5. A man walks into a bar with a slab of asphalt under his arm, and says: 'A beer please, and one for the road.'

6. Two cannibals are eating a clown. One says to the other: 'Does this taste funny to you ?'

7. 'Doc, I can't stop singing 'The Green, Green Grass of Home.' 'That sounds like Tom Jones Syndrome.' 'Is it common ?' 'Well, It's Not Unusual.'

8. Two cows are standing next to each other in a field. Daisy says to Dolly, 'I was artificially inseminated this morning.' 'I don't believe you,' says Dolly. 'It's true; no bull!' exclaims Daisy.

9. An invisible man marries an invisible woman. The kids were nothing to look at either.

10. Deja Moo: The feeling that you've heard this bull before.

11. I went to buy some camouflage trousers the other day, but I couldn't find any.

12. A man woke up in a hospital after a serious accident. He shouted, 'Doctor, doctor, I can't feel my legs !' The doctor replied, 'I know you can't - I've cut off your arms !'

13. I went to a seafood disco last week...and pulled a mussel.

14. What do you call a fish with no eyes? A fsh.

15. Two fish swim into a concrete wall. One turns to the other and says, 'Dam !'

16. Two Eskimos sitting in a kayak were a bit cold, so they lit a fire in the craft. It sank, proving once again that you can't have your kayak and heat it too.

17. A group of chess enthusiasts checked into a hotel, and were standing in the lobby discussing their recent tournament victories. After about an hour, the manager came out of the office, and asked them to 'disperse'. 'But why,' they asked, as they moved off. 'Because,' he said, 'I can't stand chess-nuts boasting in an open foyer.'

18. A woman has twins, and gives them up for adoption. One of them goes to a family in Egypt , and is named 'Ahmal.' The other goes to a family in Spain ; they name him 'Juan.' Years later, Juan sends a picture of himself to his birth mother. Upon receiving the picture, she tells her husband that she wishes she also had a picture of Ahmal. Her husband responds, 'They're twins ! If you've seen Juan, you've seen Ahmal.'

19. Mahatma Gandhi, as you know, walked barefoot most of the time, which produced an impressive set of calluses on his feet. He also ate very little, which made him rather frail and with his odd diet, He suffered from bad breath. This made him (Oh, man, this is so bad, it's good) A super-calloused fragile mystic hexed by halitosis.

20. And finally, there was the person who sent twenty different puns to his friends, with the hope that at least ten of the puns would make them laugh. No pun in ten did.

CLASSIFIED

GP Locum Work Wanted: Full / Part Time - Available from September 2011. Male, 1966 Adelaide Graduate MBBS, Full VR registration and open prescriber / provider numbers.

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REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION MEMBERSHIP

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

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

Meeting dates are in the date claimers on page 4

COST for non-members:

$30 for doctor, non-member

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CHANGES TO CLASSIFIEDS

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

Classifieds will be published for a maximum of three placements.

Classifieds are not to be used as advertisements.

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

EXECUTIVE DIRECTOR, REDCLIFFE HOSPITAL

Metro North Health Service District
Donna O'Sullivan,

Skills Development Centre

In June 2010 we opened a new Skills Development Centre at Redcliffe Hospital and I'm pleased to report that expanding the way we provide skills and professional development opportunities has had a very positive uptake among our staff and educators.

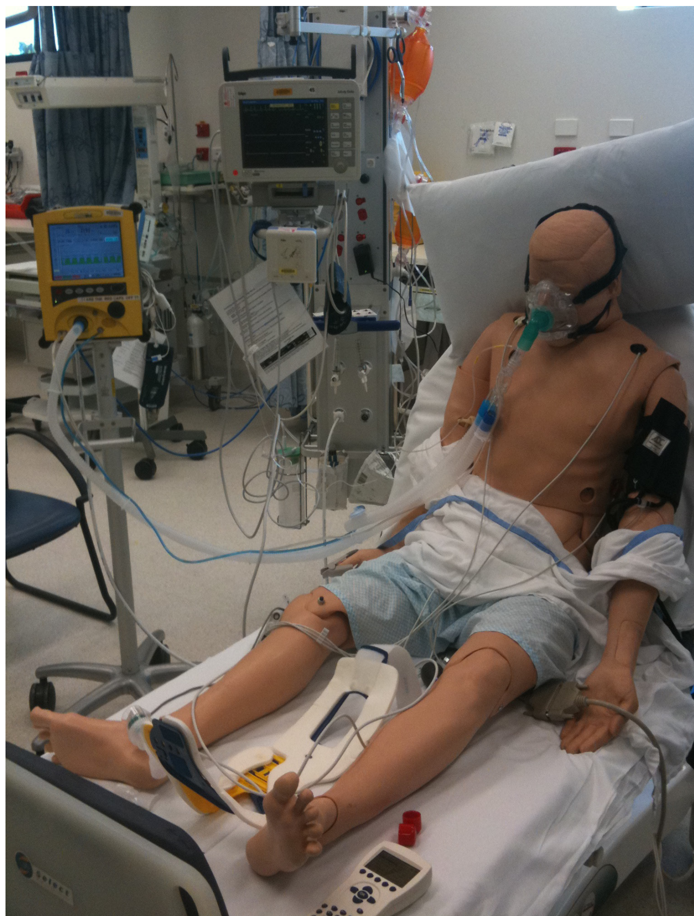
When we committed to this project, in partnership with the University of Queensland Northside Clinical School, we did so with the main aim of providing access to and enhancing the skills development opportunities for our health professionals and students in a safe and secure environment.

The centre is fully equipped to facilitate innovative learning methods and deliver education, skills enhancement and skills development activities. Primarily these activities take the form of scenario-based learning and skills based teaching.

The facility itself accommodates five rooms including two simulation rooms, two skills labs and a debrief/ lecture room, which is used in conjunction with skills training or scenario based learning.

It has an array of interactive manikins and training equipment specifically for skills development and enhancement across a wide range of areas. The manikins – aptly named 'Simman' and 'Simbaby' replicate the clinical condition of a patient making for a more realistic experience and we are able to alter our simulation rooms in order to reproduce a range of clinical settings. This equipment and learning process is supported by two fully trained simulation coordinators, with extensive clinical, simulation and education experience.

By having a campus-based facility we can tailor our activities to meet the specific and unique needs of those we provide care for. And the centre links quite closely with the Centre for Healthcare Improvement at the Royal Brisbane and Women's Hospital Campus in Herston. This means we have access to a vast array of equipment and other teaching resources which are available at a tertiary-level hospital - again providing more professional development options for our staff.



Redcliffe Hospital's Education and Skills Centre has a simulation room and an array of interactive manikins and training equipment to reproduce a range of clinical settings.

Since opening, our staff have had access to a dedicated skills development centre in addition to the clinical expertise which resides within our hospital walls. And our staff have not been the only ones to benefit, undergraduate nursing and medical students have also made good use of the facility and resources.

Of course the result of better training for our staff is that our patients, in the long-run, will benefit.

Donna O'Sullivan
Executive Director, Redcliffe Hospital

From Page 4

Rebate system

• The RACGP work with public hospitals and other suitable hospitals to improve unsatisfactory features of FMP training and to extend hospital places for FMP trainees.

• The RACGP's FMP Evaluation Task Force resume its activity immediately and develop an evaluation protocol for implementation by the end of 1989.

• The evaluation task force publish its results annually.

The Committee reported that it endorsed the profession's support for Continuing Medical Education and recommended that CME and Quality Assurance be the responsibility of the medical profession.

It said post graduate medical associations and universities should be encouraged to provide alternative, accredited programmes of CME and the RACGP should be responsible for accreditation of all CME programmes for general practice.

The Committee acknowledged that there had clearly been insufficient and inadequate consultation with the profession by the RACGP during the development of the proposal and since its announcement.

It said this weakness had contributed to anxiety about, and hostility to, the proposal.

In the committee's own words, it was clear the proposal had not been explained to the profession with sufficient clarity.

The committee heard evidence of GPs receiving different and contradictory answers to similar questions or anomalies, giving the impression of "policy making on the run."

"It is in the best interest of both the College and the medical profession for theRACGP to revert to its proper role of arbiter of professional standards," the committee said.

"For the RACGP to withdraw from other political negotiations it is clearly necessary for the AMA to re-enter that arena as principal negotiator for the profession in scheduled fee and other related negotiations with the Government," it said.

Beyond power

"Such a development is clearly beyond this committee's power to demand. However, it is a development that it would welcome."

The committee recommended instead that the AMA negotiate with the Government on Medicare Benefits Schedule fees and rebates and that the Government invite the AMA to be involved in consultations about the implementation of the recommendations of the report.

It further recommended that the AMA be invited to participate in the standing review group on General Practice to be established between the Department and the RACGP.

A further recommendation was that the Standing Review Group consider how financial assistance could be provided to general practitioners to encourage health promotion and illness prevention services.

In its final pages, the committee said processes for monitoring and evaluating the undergraduate and pre-registration training of general practitioners, and the outcomes for general practice should be developed.

Such a process of evaluation should be used to ensure that the vocational training of general practitioners should be constantly modified to reflect changes in undergraduate and pre-registration training and the changing demands of general practice.

It recommended that the RACGP and the Commonwealth enter into discussion with Australian universities and "other appropriate bodies" with a view to:

• Establishing appropriate evaluation techniques, to examine various factors affecting the quality of general practice;

• Establishing research programmes to monitor the effect of the changes in health outcomes and in general practice.

Its final recommendation was that the special problems of rural general practice be listed for urgent consideration by the Australian Health Ministers Conference.

Small group has a high profile

Immediate past president, Dr Rob Hodge, wants to know why the Doctors Reform Society is allowed to enjoy such a high profile among sections of the Australian media.

According to figures compiled by Dr Hodge, the Redcliffe and Districts Local Medical Association, on its own, has a membership bigger than the DRS.

Australia wide, the DRS has 225 members, compared with more than 300 in the Redcliffe LMA.

And, says Dr Hodge, the DRS has taken 17 years to accumulate that many.

His complaint is that a large section of the media frequently refers to the DRS for comment on medical/political matters, as representatives of medicine generally.

But he sees them as little more than a vocal minority and ginger group with strong tendencies to "Laborite" ideas and views that only cause concern and dismay among the general public.

Dr Hodge says the Redcliffe LMA has a greater right to be considered as representative of the medical profession, because it is the largest AMA local branch in Australia and embraces a greater range of medical disciplines.

Deception Bay's Historical Article

Deception Bay, Queensland

Deception Bay is a suburb approximately 32 kms north of Brisbane's central business district. On 15 March 2008, Deception Bay became a suburb of a new super council, Moreton Bay Region. Deception Bay divided into two divisions, with the area of the suburb falling north of Deception Bay Road becoming a part of Division 2. It is in the State Electoral District of Murrumba under the Federal Division of Longman.

The suburb has one major high school, Deception Bay State High School, and three primary schools. There is one Catholic Primary School Christ the King Catholic Primary School. Many local children attend school outside the immediate area.

The curiously named town of Deception Bay lies at the southern end of the bay of the same name which separates the Redcliffe peninsula and Bribie Island. Deception Bay was named by Lt John Oxley in 1823. Lt Oxley thought the bay was unusually shallow and deduced that it was a river which he named Pumice Stone River. Once he realised his mistake he later changed the name to Deception Bay.

In recent times Deception Bay is often abbreviated in name to D-Bay. This term, is mainly used by outsiders, organisations or recent arrivals to Deception Bay. The suburb has previously been plagued with crime and high unemployment during the 1980s and 1990s. This was due in part because it was populated with one of the most concentrated social housing in Queensland by the government of the day. Community problems subsided after 2001 due to redevelopment and population growth in the area.

Settlement

The once rich pastoral and grazing land has now become an established and growing residential area. Deception Bay's sheltered location accesses both the river and bay making it an excellent spot for recreational activities, boating and fishing pastimes.

Cottonwood Walk is a must-do visit when in Deception Bay. This beautiful peaceful area along the esplanade incorporates timber boardwalks, barbecues, viewing platforms and picnic facilities. It offers glorious bay views and is a perfect spot for a family picnics and entertainment for both adults and children.

A notable resident of Deception Bay was Dr Joseph Bancroft, a pioneer in experimenting in native plants for their health properties and, through his meat-works, in the preservation of meat, fish and vegetables. His son, Thomas, carried on the tradition with some work in cultivating cotton and castor oil. A rough-hewn pyramidal block of granite stands today on the foreshore highlighting the achievements of these two doctors, and the streets around Dr Bancroft's home, Joseph Street and Bancroft Terrace, are named in his honour.

At low tide, exploration of the mudflats towards the north east corner can find two unusual baths excavated out of bed rock. The baths are named Bancroft Bath Number 1 and Number 2, these curious structures were created in the late 1800s by Joseph Bancroft as a type of salt water hydrotherapy unit, for his sick wife to bathe in. Mrs Bancroft's bath, on the foreshore of the bay, can be visited still today.

Local residents are proud of the contribution the Bancroft Family has made to the early historical development and progress of Deception Bay.

Now days families enjoy the public swimming pool complex featuring a 50 metre Olympic size pool, wading pool, enclosed heated lesson pool, toddlers pool and play area. There is also a BMX and skate park in the area where children and teenager can let loose and practice their latest tricks on wheels.

In the past few years, the beach front area has received a major re-design, under the urban renewal programme of the Queensland Government. The growing suburb also contains a new development area, North Rise. Bayswater Resort is a resort currently under construction in the Moreton Downs Estate which has neighbouring suburbs including Rothwell, Narangba and North Lakes.

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SESSION HIGHLIGHTS

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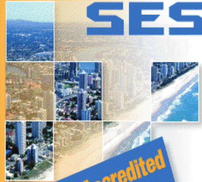

**Conference Accredited for QI & CPD Category 2 Points.
RACGP approved with a maximum of 25 Category 2 Points.**

• OPHTHALMOLOGY

How to lose your Glasses in the 21st Century

FRIDAY 3pm

Refractive Laser surgery has advanced significantly since the 1980s. In 2011, new lasers have resulted in faster operations, significant improvement in accuracy and reduction in risks, thus making these procedures the most performed in modern medicine.

A summary of the lastest techniques and femtosecond lasers will be presented.

Speaker: Dr Marc Wei
FRANZCO

Dr Marc Wei has being practising on the Gold Coast for 10 years specialising in refractive laser and cataract surgery. (Lasersight)

He graduated from University of Queensland in 1989 and underwent specialist training in ophthalmology in Brisbane culminating the Fellowship of Ophthalmology in 1998.

He obtained further subspecialty training in glaucoma, cataract and paediatric ophthalmology at the Great Ormond Street Hospital for Sick Children and at Kings College Hospital, London, UK.

He is a member of the American Academy of Ophthalmology, European Society of Refractive and Cataract surgeons and the Australasian Society of Cataract & Refractive Surgeons and is actively involved in research and presentations at international ophthalmic conferences.

• SURGERY

Military Anaesthesia – the Australian Experience

FRIDAY 10.30am

Dr McLaren was the anaesthetist in a surgical team embedded in the Netherlands military hospital in Tarin Kowt, Uruzgan Province, Afghanistan in the northern spring of 2009. He uses this experience and the accumulated experience of NATO and Coalition medical teams to detail changes in current trauma management.

Speaker: Dr Peter McLaren
MBBS(NSW) FANZCA

Dr Peter McLaren was born in Dubbo, NSW. He graduated MBBS from University of NSW in 1977. Further experience was gained in Perth, Kalgoorlie, Wyndham and Papua New Guinea before commencing anaesthesia in Plymouth, UK. He completed anaesthesia training in Brisbane and Perth before commencing specialist practice in Lismore, NSW in 1985.

Dr McLaren joined the Army Reserves in 2002 and has deployed to East Timor several times and once to Afghanistan. He moved to the Gold Coast in 2005 and is currently President of the Gold Coast Medical Association.

• ONCOLOGY

Fertility Preservation for Oncology Patients

SATURDAY 10.30am

Infertility can be a consequence of oncology treatments. Parallel improvements in both the survival rates following oncology treatment and the assisted reproductive technologies have made consideration of fertility preservation an important part of the management of patients being treated for malignancies.

Cancer diagnosis and treatment is a multidisciplinary process. It is those involved in its earliest phases, the general practitioner and the oncology nurse, who can significantly contribute by encouraging consideration of fertility preservation options well before oncology treatment is to commence.

Speaker: A/Prof Keith Harrison

Keith Harrison is the Scientific Director of Queensland Fertility Group, Queensland's first and largest assisted reproduction programme which has clinics throughout the state. All clinics offer the full range of fertility preservation services for oncology patients.

Keith has over 90 publications in peer-reviewed journals. He has a major interest in male infertility, factors affecting it and strategies for overcoming it.

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eMJA

PATIENT COMPLAINTS CLAIM DOCTORS FAIL TO PROPERLY DISCLOSE COMPLICATION RISKS

EMBARGOED UNTIL 12 NOON SUNDAY, 18 SEPTEMBER 2011

In more than 70 per cent of legal disputes over consent to treatment issues patients allege that the treating doctor failed to properly explain risks of complications, according to research published in the latest *Medical Journal of Australia*.

Prof David Studdert, from the Melbourne School of Population Health and Melbourne Law School at the University of Melbourne, and co-authors reviewed nearly 2,000 negligence claims against doctors insured by Avant Mutual Group Limited and complaints lodged with the Health Services Commissioner of Victoria. The review focused on alleged failures in the consent process that were adjudicated between 1 January 2002 and 31 December 2008.

The authors found that the primary allegation in 71 per cent of these cases was that the doctor failed to mention or properly explain risks of complications.

Lead author, Dr Andrew Gogos, said that 92 per cent of cases involved surgical procedures and 16 per cent involved cosmetic procedures. Plastic surgeons experienced complaint rates that were more than twice those of any other specialty or subspecialty group.

"The concept of a 'typical' informed consent dispute has real currency: it is an operation, often undertaken for cosmetic purposes, in which the patient alleges that a complication was not properly disclosed," Dr Gogos said.

"To the best of our knowledge, this is the first study to investigate in a real-world setting what happens when informed consent goes poorly from the patient's perspective.

"Improved understanding of these situations helps to spotlight areas of care in which there is a gap between what doctors do and what patients want.

"It may also be helpful for clinicians who want to avoid getting drawn into legal disputes.

"Consistent with the quality improvement mantra that 'every defect is a treasure', this study shows that further research into disputes over informed consent and other preventable breakdowns in care is warranted."

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

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

CONTACT: Prof David Studdert 0407 083 444
Ms Rebecca Scott 0417 164 791
Media Officer
University of Melbourne

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

STRATEGIC WORKFORCE PLANNING NEEDED

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA Position Statement on Prevocational Medical Education and Training 2011

The AMA today released its Position Statement on Prevocational Medical Education and Training – 2011.

AMA President, Dr Steve Hambleton, said that the significant increase in medical student numbers in Australia puts additional pressures on the health system to provide clinical training for students and junior doctors.

"The AMA has called for an overarching medical workforce plan that ensures there is an appropriate number of adequately funded undergraduate, prevocational and vocational training places," Dr Hambleton said.

"It is simply not enough to graduate more medical students without providing students and junior doctors with the jobs and training they need to meet the needs of the community.

"The quality of medical training may be eroded if investments in supervision and supporting infrastructure do not match the growth in trainee numbers.

"The AMA Position Statement outlines the fundamental arrangements and resources that need to be in place to ensure that Australia maintains its enviable reputation for medical workforce training.

"Profession-led accreditation arrangements are one of the strengths of medical education in Australia.

"Employers should be accredited to agreed standards before being permitted to employ prevocational trainees.

"These standards have been developed by the Postgraduate Medical Councils and should underpin the delivery of quality prevocational medical education.

"As well as meeting accreditation standards, employers of prevocational trainees must have appropriate workplace policies that focus on junior doctor health and wellbeing.

"This extends to safe working hours, fatigue management, and flexible working arrangements so that an appropriate work-life balance can be obtained.

"Keeping junior doctors healthy means they can deliver high-quality health care to their patients and the community, and experience medicine as a rewarding and satisfying career."

The Position Statement highlights other areas where investments are needed to match the growth in trainee numbers, including in curricula, internship, supervision, feedback and assessment, and competency-based training and assessment.

The Position Statement is available on the AMA website at http://ama.com.au/node/7084

6 September 2011

CONTACT:

Geraldine Kurukchi

02 6270 5467 / 0427 209 753

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

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

Dear Doctor

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

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

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

Yours sincerely

Dr Peter Stephenson
Treasurer

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION INC.

ABN 88 637 858 491

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

Tick box **1.☐ One Member ($100) 2. ☐ Two Family Members ($150)** **(Complete BOTH sets of details)**

3. ☐ Doctors-in-training and retired doctors: Free

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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**

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Deception Bay - Great Northern Garden