RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
SEPTEMBER 2012

Woodford

See Woodford in our historical article in our regular Where We Live And Work segments page 3 and 20.

RDMA President's Message ... Dr Wayne Herdy

RDMA PRESIDENT'S REPORT.

RDMA has a new Executive Committee that looks remarkably similar to the previous committee. To be more precise, is it identical. This is good for the Association because the organization remains in experienced hands who know RDMA well and can be trusted with its future welfare. It is NOT so good for the organization that there are no new faces, no fresh ideas from enthusiastic minds who might inject renewed vigor. While I am flattered that our members have confirmed a vote of confidence in the old guard, I would have liked to see others prepared to donate their time and their intellect to our Association. Next year.....

We have already held our policy and planning meeting to set a course for the coming year. My personal Presidential style is very democratic – while I initiated most of the issues discussed at that meeting, not one of them would have proceeded without the unanimous support of the entire committee. That is not a way of pre-emptively sharing the blame for anything that goes wrong; it is a way of ensuring that all opinions are included. The minutes of that meeting are printed in these pages. Please read those minutes – this is your best opportunity to influence the short –term path of your Association. If there are any plans in there that you violently disagree with, we need to hear about them. Are there any future plans that we overlooked?

Let's look forward to another year of ongoing success. Most importantly, let's start introducing new members to our fold, especially the youngest members of our profession. Every member should be participating in the process of recruitment of new members – you collectively have more contacts than any of the committee to whom you have entrusted RDMA.

Wayne Herdy.

DATE CLAIMERS:

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

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

2012 Dates:

NEXT MEETING

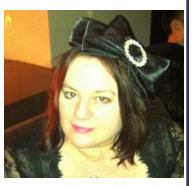
Wednesday October 24

Year End Networking Function

Friday November 30

CONTACTS:

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



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OCTOBER NEWSLETTER 2012

The 14th October 2012 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com
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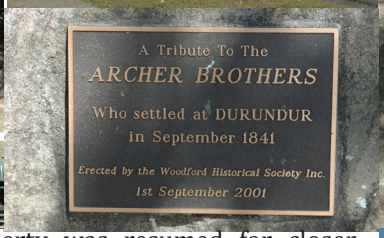
Woodford



Woodford, Queensland

Woodford a small town in Queensland, Australia, on the D'Aguilar Highway, 72 km north-west of Brisbane, 24 km west of Caboolture and is noted for various festivals held in its midst annually. The Woodford Folk Festival is held annually in December and in October 2010 and 2011 Splendour in the Grass, the Australian Music Festival was held in the same location as well as the Dreaming Festival which is an Aboriginal cultural event. On the outskirts of the town is the Woodford Correctional Centre.

The earliest European settlement in the area was the Archer brothers' Durundur pastoral run (1840) which ran along the Stanley River. After the lease of Durundur expired in October, 1878, some land was thrown open for selection. Part of the Durundur property was resumed for closer-settlement and for an Aboriginal protection station (1877-1905). More selectors followed in 1902 with a second closer-settlement scheme.

After several ownership changes Durundur, came under the management of Henry C. Wood in 1867 until 1891. He was a member of the Caboolture local government division and was a Queensland parliamentarian from 1886-1902. It was in his honour the township was named "Woodford' in joint recognition of the importance to the community of the ford across the river.

It was during the 1920s and 1930s that Woodford expanded, with the opening of the Stanley River cooperative butter factory, a bush-nursing hospital (1922-63), a Catholic primary school and a Diggers memorial hall. In the immediate postwar years there were still three hotels, a picture theatre, two sawmills, two box and case makers, cordial makers, motor garages, regular racing club meetings, a golf club, a bowls club and four churches. Most farmers listed in the post office guide in 1949 were in dairying. The closure of the bush-nursing centre and the railway in 1963 and 1964 signified a decline in the district's economy, but the building of the Woodford prison in 1973 has produced an unexpected source of resurgence, prosperity and local employment

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT
Dr Alex Markwell

Update from AMAQ President

This month has been dominated by the 2012/13 Queensland State Budget, public service redundancies and devolution of public health programs.

It has been a particularly challenging period and we're conscious that many of our members have suffered stress as a result of the uncertainty.

For months we have been awaiting details from the Health Minister on the expected total of redundancies and confirmation of the corporate office health services that would be devolved out to the districts.

The standard response of the government on these issues has been to shift responsibility to the HHS Boards. The boards have been given a target of FTE to cut, starting with vacancies and temporary contracts. Boards are already straining under immense pressure to meet targets, and in many areas these cuts are unrealistic and ill-advised.

The earlier announcement by the Minister that Queensland Health was to shed 2754 FTE positions was contradicted by the Budget which put the number at 4140 FTE. This discrepancy caused even more distress for health workers and subsequent explanations from the government have been unclear and unsatisfactory.

In the absence of consistent information, rumour, fear and anxiety are spreading throughout the state and we have been contacted by many concerned members. Some are worried for their own job security, others about the fate of colleagues and associates.

The fact is we are still in the dark about exactly which health workers will lose their jobs, and when and how, those cuts will impact the 17 hospital and health services.

Unofficial sources have indicated the most significant job and service cuts are in the areas of preventative health, health promotion and public health programs such as the Queensland Tuberculosis Control Centre which, which has been dismantled against our advice.

Another area of concern is the government's plan to outsource as many services as they can, a move that may undermine the public hospital system and its ability to train and retain doctors and health care staff.

The Budget did offer some small concessions. An increase of approximately seven percent in health funding has been applied although based on current population growth and CPI trends this will soon be swallowed up by increased cost and demand for services.

Pre-election promises such as increased patient travel subsidies, expanded maternal and early child health services and more hospital staff on weekends were the only bright lights in an otherwise short-sighted and uninspiring effort for a first-term government.

We will continue to push for more information and keep members and the public informed as new details come to light.

As always, your feedback and suggestions are welcomed. Please call or email me.

Dr Alex Markwell, AMAQ President
Phone: (07) 3872 2222
Email: a.markwell@amaq.com.au

5 THINGS YOU PROBABLY NEVER KNEW YOUR MOBILE PHONE COULD DO

There are a few things that can be done in times of grave emergencies.

FIRST Emergency
The Emergency Number worldwide for Mobile is 112.
If you find yourself out of the coverage area of your mobile; network and there is an emergency, dial 112and the mobile will search any existing network to establish the emergency number for you, and interestingly this number112can be dialled even if the keypad is locked. Try it out.

SECOND
Have you locked your keys in the car? Does your car have remote keyless entry? This may come in handy someday.
Good reason to own a cell phone:
If you lock your keys in the car and the spare keys are at home, call someone at home on their mobile phone from your cell phone.

Hold your cell phone about a foot from your car door and have the person
at your home press the unlock button, holding it near the mobile phone on their end.

Your car will unlock.
Saves someone from having to drive your keys to you.
Distance is no object.
You could be hundreds of miles away, and if you can reach someone who has the other 'remote' for your car, you can unlock the doors (or the boot).

Editor's Note: It works fine! We tried it out and it unlocked our car over a mobile phone!'

THIRD
Hidden Battery Power. Imagine your mobile battery is very low.
To activate, press the keys*3370# Your mobile will restart with this reserve and the instrument will show a 50% increase in battery.

This reserve will get charged when you charge your mobile next time.

FOURTH
How to disable a STOLEN mobile phone? To check your Mobile phone's serial number,key in the following digits on your phone: * # 0 6 #

A 15 digit code will appear on the screen. This number is unique to your handset. Write it down and keep it somewhere safe. When your phone get stolen, you can phone your service provider and give them this code.

They will then be able to block your handset so even if the thief changes theSIMcard,your phone will be totally useless.

You probably won't get your phone back,but at least you know that whoever stole it can't use/sell it either.

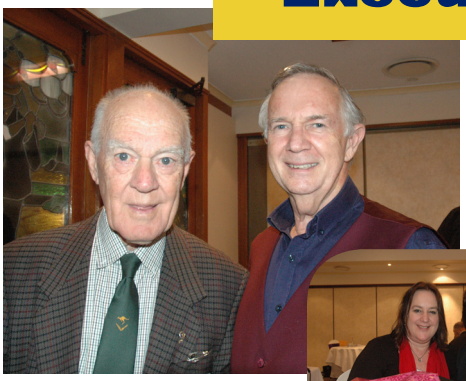
If everybody does this, there would be no point in people stealing mobile phones.

FIFTH
ATM - PIN Number Reversal - Good to Know If you should ever be forced by a robber to withdraw money from an ATM machine, you can notify the police by entering your PIN # in reverse. For example, if your pin number is 1234, then you would put in 4321.

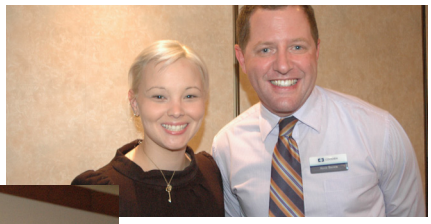
The ATM system recognizes that your PIN number is backwards from the ATM card you placed in the machine. The machine will still give you the money you requested, but unknown to the robber, the police will be immediately dispatched to the location.

This information was recently broadcast on CTV by Crime Stoppers. However it is seldom used because people just don't know about it. Let us know if it works?

RDMA AGM Meeting 29/08/12
Executive Team Re-elected









RDMA President Wayne Herdy opened the meeting introducing Dr Blair Bowden whose topic for the evening was "Is Your Patient's Weight Worth Their Health". Richard Dennis represented the evening's Sponsor the Allergan Australia.

Clock wise from Bottom left hand corner: Newly Eected President Wayne Herdy congratulated Margaret McPherson on her continued support for the last year. Newly Elected Vice President Kimberley Bondeson presents a gift to Margaret McPherson and Tracey Blackmur. RDMA Patron Reg Neilsen with New President Wayne Herdy. New Executive Team: Treasurer Peter Stephensen, Secretary Ken Fry, Vice President Kimberley Bondeson and President Wayne Herdy. Colin Kennett & Kristy McKenzie, Lara Jacob (Dr Bowden's Practice Manager) & Adam Brown, Coviden Representative, Mahilal Ratnapala, Pravin Kasan Returning Officer announcing new executive, Richard Dennis & Speaker Blair Bowden.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: **Tuesday 18th September 2012**

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: GSK Pharmaceuticals Represented by: Clarissa Camus
7.40pm	Speaker: Assoc. Professor Ian Yang Topic: Update on COPD Management – with local case study
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 14th September

QML Pathology.

AMAQ BRANCH COUNCILLOR REPORT
North Coast Area Representative
Dr Wayne Herdy

The State Budget and Government Cutbacks

THE STATE BUDGET is upon us. A copy of the AMAQ media release is printed in this Newsletter.

The big issue is job cuts. The cruel reality is that the new government had to reign in spending, or Queensland was facing inevitable bankruptcy.

Spending cuts had to mean job cuts. Job cuts might or might not mean reduced services, depending on how efficient the department was running. Big cuts do not necessarily translate into proportionately big cuts in service delivery, especially when we are talking about an incredibly large and cumbersome public bureaucracy.

The important issue economically was how far to cut the size of the public service. I recall that when Gordon Nuttall was Minister for Health we applauded his announcement of some millions of new dollars to increase QHealth by 90-something staff, yet a year later were moaning that not one of those 90-odd new faces was a doctor or nurse.

The important issue politically was how quickly to do it and – since Campbell Newman chose to make cuts very quickly – how to sell it to the voters so that they will remember the pleasure and not the pain when the next election comes around.

Queensland Health is bearing its share of the manpower losses. What we do not know yet is how much the losses will be confined to the corporate office and how much will be trimmed from front-line clinicians (nurses and allied health as well as doctors).

Doctors are genetically programmed to be outcomes-focused. The outcome as measured by patient benefits will be what determines whether the medical profession will be happy with the outcome when the next Budget comes around.

The raw figures as we see them today are vague and (remembering that Newman had a military background) neatly camouflaged. Many of the jobs lost from the public sector will be compensated by outsourcing. Hospitals will still need cleaners and gardeners, whether they are employed directly by the government (with the bureaucracy that supports them in turn) or whether they are employed indirectly via contracts.

One aspect that has received barely a whisper is the unhappy fact that there are hundreds of QHealth employees on the payroll who are paid to sit at home all day – a doctor who has been stood down on full pay would cost the taxpayer a half a million dollars a year, and there are possibly a dozen of our colleagues sitting in that uncomfortable armchair.

And my closing point on this for today is to remind my readers that public health systems sometimes have big staff numbers for good reasons, because they perform roles that the private sector cannot perform (or at least not to the same scale).

Severe acute trauma and major life-threatening illnesses are found in public hospitals far more frequently than in private hospitals.

Research and teaching are not the primary domain of the private sector (OK, I know that there is some research and training in the private sector, but really, where is most of it done?).

Governments monitor population health best, and manage interventions best in scenarios such as epidemics and natural disasters (hey, I didn't say they always do it well, just that they do it better than anybody else could).

Wayne Herdy
AMAQ Councillor

RDMA VICE PRESIDENT & AMAQ COUNCILLOR REPORT

Dr Kimberley Bondeson

HEALTH CUTS, TB & ENT SERVICES and AMAQ CONFERENCE IN MADRID

Another month has gone by and we have seen some dramatic changes in Health. Particularly the job cuts that are being rolled out by the government across the board, and in particular Queensland Health.

It remains to be seen if these cuts are successful in decreasing costs. Even though the government has said that front line services will not be effected, there are nursing and pathology services across the state that have been slashed, and the flow on from this is obviously a decrease in patient care. Once the new budget has been rolled out and the dust settles, we will get a clearer view.

TB services has been decentralized and now we will again have to wait and see if the new system is workable.

On another topic of frustration, there is no ENT services available for children in the district. One of my patients had been waiting on the waiting list for an appointment (yes, that secret waiting list) at the Royal Childrens for 3 years, and finally turned 16 years old. They then received a letter to say that they had to go to the Adult Hospital, and onto its waiting list.

Logan hospital, are now sending out letters saying try somewhere else, as they are still waiting for funding for 2011-2012. And of course, neither Redcliffe nor Caboolture Hospital have any ENT services.

Well, I am off to Madrid shortly where we will be discussing "Preventative Health Strategies for the 21st Century", so I will be able to bring back an update on areas that are relevant to us.
Kimberley Bondeson

SNAPSHOT FROM THE PAST GP Recognition-Early Discharge

REDAMA Newsletter from Series 2 No 4 September 1990, page 5

The Home Care Debate

ALL local State parliamentarians in the northern regions of Brisbane have been polled on the medical profession's stance on the Early Discharge Patients scheme at Redcliffe Hospital.

A letter, outlining medical concern at some implications of the scheme, has been sent to local members for electorates in the Redcliffe Hospital catchment area.

In it, the Redcliffe and Districts Local Medical Association urges the members to urgently approach the Health Minister, Mr McElligott, and acquaint themselves with the scheme.

It also warns that the association plans to monitor patients returning to the community under the early discharge system, and to publicise any problems that arise.

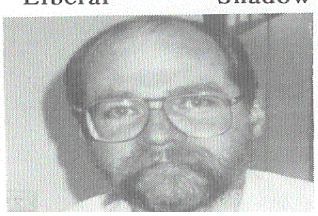
Secretary, Dr John O'Reilly, asks the parliamentarians to help ensure that general practitioners become central to the care of patients, thereby helping to minimise any increase in morbidity or mortality.

The case has already attracted political interest.

Liberal Shadow spokesman on Health, Joan Shelden, has written to Dr O'Reilly, seeking more details on the matter.

She said she was concerned at the implications of the scheme and wanted to be fully informed of the medical profession's objections.

Dr O'Reilly will provide the information as a matter of urgency.



Politicians asked to help medico campaign on early discharge

GPs recognised in revised guidelines to pilot scheme

GENERAL practitioners have been given "central role" importance in the State Government's "early discharge scheme" on trial at Redcliffe Hospital.

Private talks between the Redcliffe and Districts Local Medical Association and the hospital Superintendent and board have reached agreement on amendments to the original pilot scheme guidelines.

LMA President, Dr David Brand, said there had been significant changes negotiated which meant general practitioners would be guaranteed their role as providors of primary health care.

But, he said, it would be necessary for the LMA to continue to maintain pressure on the Health Minister to review the scheme and declare it "safe."

"We have told the Hospital Board that members of the LMA will be invited to monitor the scheme and advise of any problems encountered by early discharge patients."

Dr Brand said the Government should be looking at conducting a morbidity survey to gauge the effects of the scheme.

"It's easy to do a mortality survey but a morbidity study would provide more telling information," he said.

Dr Brand said members of the association should make themselves available to address affected community groups, such as pensioners, to explain the implications of the scheme.

"This should have been done by the Government but it is something we can do to help overcome any misunderstandings which may have arisen," he said.

Dr Brand described the scheme as an example of "health care that's cost driven rather than medically driven."

"The Government should be looking at encouraging proper medical systems before it starts cutting financial corners without any consultation with the medical profession.

"The Hospital Board has taken real steps to address the problem areas we have identified and we are confident the changes will represent a vast improvement when the final details are completed," he said.

Redcliffe & District Medical Association Inc.

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Minutes of RDMA Inc. **Executive Committee Meeting** Wednesday 5th September 2012
Venue: The Ox, 330 Oxley Avenue, Margate
Attendees: Dr Wayne Herdy (President), Dr Kimberley Bondeson (Vice President), Dr Ken Fry (Secretary) Dr Peter Stephenson (Treasurer), and Margaret MacPherson (QML – Meeting Convener)

1910 Wayne Herdy opened meeting

The purpose of the meeting is to affirm the policy of RDMA and to implement that policy in determining planned activities and direction for the coming year.

1.Any change of direction for the coming year?

It is not proposed to depart from the established pattern of monthly meetings held at least 10 times a year, with a clinical topic being presented and usually attracting the sponsorship of a health partner.

The meeting discussed issues of Medicines Australia approval and the duration of presentations.

2.Topics for focus action

RDMA will be closely watching

- The local hospital board
- The Medicare Local
- The GP Super Clinics

3.Website development and content

Moved by Kimberley Bondeson
Seconded by Peter Stephenson

That the president be authorized to negotiate a contract for a professional to develop a website for RDMA to a maximum cost of $2,000.00

4.Newsletter

(a) Is any change of presentation, format or content necessary?

Meeting agreed that it is necessary to continue with an online and hard copy format.

Suggest a html file in preference to pdf file.

(b) Publisher remuneration

RDMA recognized that the newsletter has been self-funded all year and has contributed to the financial security of the organisation

It is proposed to re-negotiate the publisher's remuneration to include (i) an hourly rate, (ii) reimbursement of costs of expendables and (iii) a price per copy of hard copy prints.

Moved by Peter Stephenson
Seconded by Ken Fry

That the president be authorized to negotiate and execute a new contract with the newsletter publisher along the lines discussed at the meeting.

It is recorded that the precise details of the contract remain commercial in confidence. This is principally to prevent creating a precedent which might influence similar contracts in other LMA's

Moved by Ken Fry
Seconded by Peter Stephenson

That RDMA pay the newsletter publisher a one off bonus of $1000 in recognition of past performance.

5.Membership

Younger graduates

There is already free membership for doctors in training

Members of the executive will undertake to attend academic presentations at Redcliffe and Caboolture Hospitals (eg Grand rounds) to promote the LMA.

6.Streamline the AGM

There are statutory requirements for an AGM eg presentation and acceptance of financial statements, appointment of an auditor.

The AGM also appoints office bearers for the coming year.

It is desirable that the present outgoing and the incoming president deliver addresses outlining the achievements of the past year (and any lessons) and the prospects for the coming year.

Nomination forms for executive committee members be circulated via the newsletter and an electronic invite one month prior to the AGM

The past two AGMs have been completed expeditiously in about 10 minutes.

7.Meeting dates 2013

Meeting dates to be confirmed by the next meeting

It is planned to invite Dr Alex Markwell, President of AMAQ to address a meeting early in 2013.

The president of federal AMA Dr Steve Hambleton will also be invited to address a meeting.

Each newsletter will contain a form permitting members to raise a motion on notice to promote discussion on pertinent topics.

8.End of year function

Date set 30th November, Venue Mon Komo Hotel

Wayne Herdy requested a date change to 7th December due to double commitments.

Mon Komo unable to comply due to being fully booked. Alternate dates & venues were also checked. Date at Mon Komo to remain. MoBooking contract states "If booking is cancelled between 2 and 6 months prior to the function or event, the deposit (25%) is forfeited".

With this information the general consensus is to retain booking and date at Mon Komo

9.Financial Planning

RDMA should allocate a sum of money, equal to the cost of one year's budget held in a fixed deposit.

Moved by Wayne Herdy
Seconded by Ken Fry

That the treasurer be authorized to explore options and deposit a sum of $20,000.00 to a term deposit at the treasurers' discretion.

It was remarked that the RDMA has benefited from a once off windfall of $11,000.00 from the proceeds of liquidation of the Moreton Bay General Practice Network

10. Executive Recognition

It is proposed that the four members of the executive be exempt from paying the annual subscription currently $100.00 in recognition of the personal effort each contributes to the association.

Because of the obvious conflict of interest this motion will be put to the next ordinary meeting of RDMA and the four executive members are expected to abstain from voting on that motion.

2100 Meeting closed

"I AM HAVING TROUBLE SWALLOWING DOC"

Globus and Eosinophilic Oesophagitis
Dr Derwin Williams - Gastroenterologist

Dysphagia, difficulty with swallowing, is common and is reported by more than 5% of the population over the age of 50. A careful history is the key to the management of patients who present with "trouble swallowing". A significant proportion of these patients do not have true dysphagia but globus, painful swallowing (odynophagia) or simply a dry mouth.

Globus

Globus is characterised by a "lump in the throat" sensation which can be persistent or variable and which is often chronic. These patients often present complaining of swallowing difficulty but on careful questioning do not actually experience dysphagia and indeed their discomfort is often relieved while swallowing.

The cause of globus is not known but reflux disease and psychological factors may be present.

Patients describing this typical "lump in the throat" sensation in the absence of true dysphagia, pain on swallowing and other alarm features (such as weight loss or voice change) are extremely likely to have globus and further evaluation will prove normal. Nonetheless, these patients should have a careful evaluation including examination of the throat, thyroid and cervical glands. Whether more detailed evaluation is appropriate at initial presentation is debatable but if symptoms fail to respond to treatment then ENT referral is appropriate to exclude other pathology.

Upper gastrointestinal endoscopy is rarely of specific value in the evaluation of these patients but if performed should include careful inspection of the hypopharynx and vocal chords.

Treatment of globus is difficult. These patients are frequently distressed by their symptoms and reassurance and explanation is essential. Empirical treatment with proton pump inhibitors is worthwhile and others may benefit from psychological therapies including medication.

Dilatation of the upper oesophageal sphincter is of controversial therapeutic value.

Eosinophilic Oesophagitis

True dysphagia is the characteristic presentation of adults with eosinophilic oesophagitis (in children the presentation includes food intolerance and reflux symptoms).

The cause of eosinophilic oesophagitis is not known but it may have an allergic basis and is more common in patients with allergic conditions such as asthma, allergic rhinitis and atopic dermatitis.

The diagnosis of eosinophilic oesophagitis is made on oesophageal biopsies and is present when there is greater than 15 eosinophils per high power field in the oesophageal epithelium.

Characteristically adults with eosinophilic oesophagitis present with a history of months or even years of recurrent dysphagia often including complete bolus obstruction.

Patients presenting in this way are best first assessed by upper gastrointestinal endoscopy which should always include oesophageal biopsies as the characteristic mucosal appearance of eosinophilic oesophagitis may not be apparent. Severe cases of eosinophilic oesophagitis may have oesophageal strictures.

A significant proportion of patients with eosinophilic oesophagitis have reflux disease but the relationship between these two conditions is not clear. Treatment options for eosinophilic oesophagitis include:

- High dose proton pump inhibitor treatment for a period of at least eight weeks.
- Ingested Flixotide.

Refractory cases of eosinophilic oesophagitis may require oesophageal dilatation or oral Prednisolone. In adults, the role of dietary modification in the treatment of eosinophilic oesophagitis is not clear.

The natural history of eosinophilic oesophagitis is poorly understood but many patients present with recurrent dysphagia when therapy is ceased and therefore long term therapeutic strategies are often needed.

(Further enquiries to Dr Williams via Montserrat ph: 07 3833 6701
or fax: 07 3833 6740)

MONTSERRAT —DAY HOSPITALS—

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #95
Safe motoring,
doctorclivefraser@hotmail.com.

FALCON XR6 TURBO "Who needs a V8?"

On Sunday 9th October an army of motoring enthusiasts will once again make a pilgrimage to the sleepy hamlet of Bathurst for another round in the Holden Vs Falcon V8 Supercar series. You see whilst Australia can rightly claim to be a secular society, we still do have some religious rituals.

The Australia Day long weekend, Anzac Day, Show Day, AFL/NRL Grand Final football and of course Melbourne Cup Day are in every Australian's calendar, even those of the non-believers. But if Australian motorists have a Mecca, it would be at Bathurst.

Since 1963 this was the place that ordinary Australian cars raced on ordinary Australian roads, Logically, a rivalry would eventually develop between the two main tribes ie Holden Vs Falcon.

In the early years the rules stipulated that the cars had to be identical to vehicles that were sold to the public.

With this in mind the Ford Cortina dominated the first three years, then the Mini Cooper in 1966.

But when the rules changed in 1967 allowing pit-stops, muscle cars viz V8's took over the lead and the advantage of going fast in a straight line was the key to success at Bathurst for ever more.

In 1969 a young 24 year old driver named Peter Brock raced for the first time at Bathurst and he would go on to be named the "King of the Mountain", winning the Bathurst race nine times. His legacy still lives on as the winner's trophy carries his name.

A little known fact about Peter Brock was that he was conscripted into the Australian Army in 1964, un-be-known to him was that another private named Dick Johnson was also stationed at the same Wagga Army Base. They would of course go on to be heroic rivals in the gladiatorial battles at Bathurst. But for the purposes of this article Peter Brock was racing for the wrong side, the "Holden Dealer Team" and I'm reviewing a Ford in this column, a Falcon XR6 Turbo no less.

Instead of taking the Ford XR6 Turbo up "The Mountain" my road test would take me around the Adelaide Hills. Bolting on the Turbo option does add $8,000 to the price of a naturally aspirated XR6, but for the extra money you do end up with an off-the-shelf car which easily out-performs the 1971 GTHO Phase III (see below).

Performance is out-standing and so is fuel economy (on the highway). I had no trouble achieving the stated 9.0 l/100km quoted in the specs on the open road. I even made a pit-stop after 500 kilometres as I thought the fuel gauge wasn't working properly, but all was in order and the trip computer was completely accurate after all.

If you are spending most of your time around town you might still take a look at Ford's EcoBoost 2.0 litre motor which returns fuel economy which is about 30% better over-all.

At the moment Ford are offering a Limited Edition XR6 model with leather seats, 19 inch wheels and a reversing camera for a cost saving of $3,824. As Ford sales are in a slump I'd say that pricing would be very negotiable.

On a final note the 50th anniversary of racing at Bathurst in 2013 will see the entrance of a third player as Nissan will enter the V8 Altima.

Ford Falcon XR6 Turbo Vs (GTHO Phase III)
For: Great performance, great value.
Against: Will it still be around after 2016?
This car would suit: Dermatologists because they have speedy consultations.
Specifications:
4.0 litre in-line 6 cylinder turbo (351 cu in V8)
270 kW power @ 5,250 rpm (291 kW @ 5400 rpm)
533 Nm torque @ 2,000 rpm (520 Nm @ 3400 rpm)
6 speed manual (4 speed manual)
6.0 seconds (6.6 seconds) 0-100 km/h
12.0 l/100 km combined
$45,990 + ORC ($5,302 + ORC in 1971).

PS. A 1971 XY Falcon GTHO Phase III in good condition is now worth $271,000 which is a compounded interest rate greater than 10% per annum over 41 years. In 2007 an un-restored GTHO Phase III sold for $683,650! Who said that cars are a bad investment?

Safe motoring,

Doctor Clive Fraser

Briefing Note

13 September 2012

Queensland Health Budget 2012-13

Summary On 1 July 2012 a new structure for Queensland Health was introduced. 17 Hospital and Health Services (HHSs) (formerly Health Service Districts) commenced operation under the governance of Boards and Queensland Health's corporate office transitioned to the role of System Manager. Under the new scheme, HHSs will provide care to patients – their budget will come from the System Manager and they will be required to sign agreements with the system manager about what services they provide and the quality of these services. If HHSs fail to meet targets set out in the agreement, the System Manager can step in to provide more supervision or change the Board or management. The 2012-13 Budget is the first budget under the new system.

Small increase in overall budget – There is an increase in budgeted spending from $11,046,410,000 in 2011-12 to $11,862,132,000 in 2012-13 representing and increase of $7.8%. However, the actual health spend in 2011-12 was $11,236,855,000. This means that, if the 2012-13 budgeted spend is not exceeded, the actual increase will only be 5.5%.
Health CPI increased by 3.6% from June 2011 to June 20121. Population growth in Queensland was 1.7% in the year ending 30 September 2011.2 If these trends continue, around 5.1% of the increase in budget will be swallowed by increased prices and population growth.

Election Promises and other special projects – The following projects will be funded to fulfil the LNP's election promises:

1 http://www.abs.gov.au/ausstats/abs@.nsf/mf/6401.0

2 http://www.oesr.qld.gov.au/products/publications/pop-growth-highlights-trends-qld/pop-growth-highlights-trends-qld-2012.pdf

- increase the subsidies provided for patients accessing the Patient Travel Subsidy Scheme ($97.7 million over four years);
- expand Maternal and Child Health Service to give all mums and bubs the best start by providing home visits at 2 and 4 weeks of age, and free consultations at community centres at 2, 4, 6 to 8 and 12 months old ($28.9 million over four years);
- increase medical, nursing and allied health staff on weekends to ensure patients can be treated and discharged without unnecessary delays;
- engage private provides to treat 'long wait' patients to reduce pressure on elective surgery in the 'Surgery Connect' program ($27.5 million over two years from 2014-15 to build access to emergency care through the continuation and expansion of the Surgery Connect program. An additional $27.5 million over two years from 2012-13 will be reallocated towards this measure, bringing total funding to $55 million);
- provide up to an additional 40,000 specialist outpatient appointments to enable better access to specialist care ($12 million in 2012-13);
- fund General Practice (GP) Liaison Officers at 20 public hospitals to improve GP referral processes across Queensland ($4 million in 2012-13);
- establish a General Practice advisory group to improve coordination and feedback between GPs and Queensland Health;
- establish a Queensland Mental Health Commission;
- develop enhanced bed management practices;
- commence the Sunshine Coast University Hospital without delays;
- delivering 3 Paediatric Intensive Care beds at the Townsville Hospital ($8.8 million over two years for a Paediatric Intensive Care Service at the Townsville Hospital. An additional $6 million will be internally allocated towards this measure in 2014-15, bringing total funding to $14.7 million);
- to put the Cairns Base Hospital on the Path to "Tier One" status, with additional funding of $15 million over four years to enable the recruitment of extra specialists to revitalise frontline services ($15 million over four years);
- $51.6 million rural and remote infrastructure rectification works at Atherton, Ayr, Biloela, Charleville, Charters Towers, Emerald, Kingaroy, Longreach, Mareeba, Roma, Sarina and Thursday Island;
- implement health awareness and prevention campaigns;
- $1.886 billion health infrastructure program;
- Funding for the Saibai Island Health Clinic ($3.7 million over three years).

Job cuts – On Friday 7 September, the Health Minister, Lawrence Springborg announced that 2,754 FTE positions would be made redundant. The Budget Strategy and Outlook paper identified that 4142 full time equivalent (FTE) positions would be lost. In response to this discrepancy the Health Minister has said: *"In my public statement on Friday, I reported that in dollar terms the budgetary starting point for these changes was a reduction of $326M or state-wide FTE savings of 4142," Mr Springborg said. I reported that at the end of the process, the monetary target will be achieved with an overall staff reduction of 2754FTE. The Health Minister released a full breakdown of the figures that transformed the dollar target and reduced the impact on health jobs. The raw figure of 4142 FTE was reduced by dollar savings equal to 1004 FTE. These savings comprised funding set aside for positions not yet created. "A further 384 positions were added to accommodate growth, a fact I detailed in a press conference on Sunday," the Minister said.* While this statement is unclear; it seems that 3138 FTE will be made redundant. However, 384 FTE positions will be added in different areas, leaving the net reduction of FTE positions at 2,754. The budget did not detail which services would be cut. It is unclear where these job cuts will be made or whether they will affect doctors. These staffing reductions will save $1.646 billion over four years. AMA Queensland is seeking further information from Queensland Health.

Reporting of HHS Budgets – Unlike in previous budgets, the budget now details the budgeted spend for individual Health and Hospital Services. These cannot be compared with last year's spending as last year's spending is not reported. See Appendix A for a summary of HHS budgets.

Efficiency Gains expected by the budget – The budget notes that Queensland's health services cost 11% more than the national average. Increased efficiency in the delivery of front line services will be expected of HHSs over coming years ($944 million over four years). The service agreements require HHSs to become 3% more efficient (except West Moreton,

which must become 4.6% more efficient in light of its significant budget deficit in 2011-12.) The budget papers state that the corporate restructure, devolution of decision-making and systemic changes will save $2.049 billion over four years from 2012-13. These cuts, assuming levels of service delivery do not also decline, are hoped to make the system more efficient. Given the high level change which occurring within the system, as well as cuts to support staff and some clinical and public health services, it will be extremely difficult for HHSs to increase their levels of efficiency.

Outsourcing – The budget also highlights a new preference toward outsourcing some previously government-run functions. This will include areas such as payroll, internal audit, metropolitan linen services, diagnostic services such as pathology and radiology, supply and logistics arrangements, biomedical technology services, the health contact centre, information technology functions such as desktop support, helpdesk arrangements and in-house hosted software development and infrastructure. HHSs will be encouraged to consider outsourcing opportunities in fields such as catering, cleaning, security, gardening and general maintenance.

Grants to external and community providers – $120 million has been cut from government grants that 'do not support core clinical services' over the next four years. A review of Queensland Health's grants program will be undertaken by a former Auditor-General of Queensland and will take into consideration the efficacy of current grants, their capacity to Queensland Health Services and their value for money.

Unrealistic targets – In addition to increases in efficiency, HHSs will be required to reach service delivery targets. Some of these targets will require a significant improvement from last year's results. Given the cuts to some programs and limited increase in funding, it will be almost impossible for HHSs to achieve some of these targets – for example category 3 wait times in Emergency Departments. Please see examples below:

Service Area: Ambulatory Care				
Service standards				
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department	18, 19	New Measure	63%	74%
Median wait time for treatment in emergency departments (minutes)		..	23	20
Percentage of emergency department patients seen within recommended timeframes:				
• Category 1 (within 2 minutes)		100%	100%	100%
• Category 2 (within 10 minutes)		80%	82%	80%
• Category 3 (within 30 minutes)		75%	62%	75%
• Category 4 (within 60 minutes)		70%	67%	70%
• Category 5 (within 120 minutes)		70%	88%	70%
• All categories	20, 21	..	68%	..
Service Area: Acute Care				
Service standards				
Median wait time for elective surgery (days):				
• Category 1 (30 days)		..	13	..
• Category 2 (90 days)		..	50	..
• Category 3 (365 days)		..	114	..
• All categories	25	..	29	25
Percentage of elective surgery patients treated within clinically recommended timeframes:				
• Category 1 (30 days)		..	88%	95%
• Category 2 (90 days)		..	78%	84%
• Category 3 (365 days)	26, 27, 28	..	90%	93%
Number of days waited at the 90th percentile for elective surgery:				
• Category 1 (30 days)		30	35	30
• Category 2 (90 days)		90	133	90
• Category 3 (365 days)		365	365	365

Discontinued measures – Some measures of health performance will no longer be measured and reported in the budget including:

- Patient Days;
- Number of available bed and bed alternatives for public acute hospitals;
- Sub and non acute patient days (including Maintenance care, Rehabilitation and Palliative Care);
- Non-admitted occasions of service;
- Acute admitted patient episodes of care;
- Mental health acute admitted patient episodes of care;
- Mental health patients assessing community mental health care.

Data on patient days and number of beds has, in the past, been extremely useful to AMA Queensland. It has allowed us to calculate hospital occupancy rates and estimate levels of overcrowding. **Capital Program** The total capital program for Queensland Health (including Queensland Health, Hospital and Health Services and capital grants) will invest $1.886 billion in 2012-13, with an additional capital investment of $21.8 million for the Council of the Queensland Institute of Medical Research.

Appendix A

Summary of portfolio budgets

Page	Agency[1,2]	2011-12 Budget $'000	2011-12 Est. Actual $'000	2012-13 Estimate $'000
1	**Health Consolidated[3]**	**11,046,410**	**11,236,855**	**11,862,132**
36	Queensland Health – controlled	11,046,410	11,236,855	11,049,034
	Queensland Health – administered	25,316	25,460	26,748
49	Cairns and Hinterland Hospital and Health Service	..	..	581,030
57	Cape York Hospital and Health Service	..	..	67,869
63	Central Queensland Hospital and Health Service	..	..	431,889
71	Central West Hospital and Health Service	..	..	51,132
78	Children's Health Queensland Hospital and Health Service	..	..	300,899
86	Darling Downs Hospital and Health Service	..	..	540,922
94	Gold Coast Hospital and Health Service	..	..	827,754
102	Mackay Hospital and Health Service	..	..	287,791
110	Metro North Hospital and Health Service	..	..	2,034,644
118	Metro South Hospital and Health Service	..	..	1,638,153
126	North West Hospital and Health Service	..	..	126,718
134	South West Hospital and Health Service	..	..	107,759
141	Sunshine Coast Hospital and Health Service	..	..	634,917
149	Torres Strait – Northern Peninsula Hospital and Health Service	..	..	81,140
156	Townsville Hospital and Health Service	..	..	699,397
164	West Moreton Hospital and Health Service	..	..	373,291
172	Wide Bay Hospital and Health Service	..	..	440,860
180	Health Quality and Complaints Commission	10,154	10,632	10,426
187	The Council of the Queensland Institute of Medical Research	82,240	76,337	96,642

Notes:
1. The Hospital and Health Services (HHS) were established on 1 July 2012. Hence there are no figures available for the HHS for 2011-12.
2. Explanations of variances are provided in the financial statements.
3. The Consolidated Budget for Health includes the Queensland Health – Controlled Budget and Hospital and Health Services Budgets with funding movements between the entities eliminated to present a consolidated position. The Health 2012-13 Consolidated Budget is comparable to the 2011-12 Budget and 2011-12 Est. actuals for Queensland Health prior to 2012-13 reforms.

2012-13 Service Summary

		Sources of Revenue			
Service area[1]	Total cost $'000	State Contribution $'000	User Charges $0'000	C'wealth Revenue $'000	Other Revenue $'000
Prevention Promotion and Protection	564,015	303,075	18,465	233,522	8,953
Primary Health Care	647,869	549,536	2,667	92,287	3,379
Ambulatory Care	2,367,073	1,549,181	149,631	652,536	15,725
Acute Care	6,201,582	3,825,488	762,964	1,569,494	43,636
Rehabilitation and Extended Care	1,009,497	522,682	44,432	330,009	112,374
Integrated Mental Health Service	1,072,096	691,166	21,705	353,191	6,034
Total	**11,862,132**	**7,441,128**	**999,864**	**3,231,039**	**190,101**

Note:
1. Explanations of variances are provided in the financial statements.

STRAIGHT TALKING IN AUSTRALIAN SCHOOLS

by Dr Ray Collins

I wonder if any teacher in this country would have the intestinal fortitude to produce a document along these lines and to introduce this sort of straight talking into the Australian public school system?

"To the students and staff of our High School, I am your new Principal, and honoured to be so. There is no greater calling than to teach young people. I would like to apprise you of some important changes coming to our school. I am making these changes because I am convinced that most of the ideas that have dominated public education in Australia have worked against you, against your teachers, against your parents, and against our country.

Firstly, this school will no longer honour race or ethnicity. I could not care less if your racial makeup is black, brown, red, blue, green, yellow or white. I could not care less if your origins are Aboriginal, Torres Strait or other Pacific Islander, Maori, Asian, Indian, Arabic, African, European or 'other'. I could not care less if your ancestors arrived here on the First Fleet, leaky refugee ships, canoes or when we were still Gondwanaland. The only identity I care about, the only one this school will recognise, is your individual identity - your character, your scholarship, your humanity. And the only national identity this school will care about is Australian. This is an Australian public school, and Australian public schools were created to make better Australians.

If you wish to affirm an ethnic, racial or religious identity through your school, you will have to go to somewhere else. We will end all ethnicity, race and non-Australian nationality-based celebrations. They undermine what it means to be an Australian in the 21st century. Everyone is equal, coast to coast, and this school will be guided by Australian values regarding egalitarianism. That includes all after-school clubs. I will not authorise clubs that divide students based on any identities. This includes gender, race, language, religion, sexual orientation, or whatever else may be in vogue in a society divided by political correctness.

Your clubs will be based on interests and passions – not blood, ethnic, tribal, racial or other physically defined ties. Those clubs just cultivate narcissism - an unhealthy preoccupation with the self - whilst the purpose of education is to get you to think beyond yourself. So we will have clubs that transport you to the wonders and glories of art, music, sport, debating, the sciences, languages you do not already speak, mathematics, woodwork and metalwork skills, and many more. If the only extracurricular activities you can imagine being interested in are those based on ethnic or racial or sexual identity, it means that little outside of yourself is of any interest to you, and that means you don't belong in this school.

Secondly, I am not interested in whether or not English is your native language. My only interest in terms of language is that you leave this school speaking and writing English as fluently as possible. The English language has united Australian citizens for over 200 years, and it will unite us at this school. It is one of the indispensable reasons this country of immigrants has always remained one and indivisible. If you leave this school without excellent English language skills, your teachers and I will have failed in our duty to ensure that you are prepared to compete successfully in the Australian employment market. Of course you will learn other languages here - it is deplorable that most Australians speak only English. But if you want classes taught in your native language rather than in English, then this is not the school for you.

Thirdly, because I regard learning as a sacred endeavour, everything in this school will reflect learning's lofty status. This means, among other things, that you and your teachers will dress accordingly. Many people in our society dress more formally for a meal at a nice restaurant than they do for church or school. Those people have their priorities backwards. Therefore, there will be a formal dress code at this school.

Fourthly, no obscene language will be tolerated anywhere on this school's property -- whether in class, in the hallways or at athletic events. If you can't speak without using racial or ethnic slurs, words such as the "F-word," "C-word or even words such as "bitch", you can't speak. It is my intent that by the time you leave this school, you will be among the few of your age to distinguish instinctively between the elevated and the degraded, the worthy and the obscene, the educated and the non-educated.

Fifthly, we will end all self-esteem programmes. In this school, self-esteem will be attained in only one way - by earning it from your fellow students and teachers. One immediate consequence of this is that we will elect our School and House Captains and there will be formal school recognition of academic, sporting and other worthy achievements.

Sixthly, and lastly, I am reorienting the school programme towards academics, scholarship, and away from politics and propaganda. No more time will be devoted to scaring you about smoking, alcohol and cannabis, or terrifying you about sexual harassment or climate change. No more courses will be devoted to condom-wearing and teaching you to regard sexual relations as only, or primarily, a health issue. There will be no more attempts to convince you that you are a victim because you are not white, or male, or heterosexual, or a Christian. We will have failed if any one of you graduates from this school not considering him or herself inordinately lucky - lucky to be alive, lucky to be well educated, and lucky to be an Australian.

Now, please stand and join me in singing, ADVANCE AUSTRALIA FAIR to the only flag that the majority of Australians recognise and accept as their own. As many of you may not know all the words, your teachers will gladly hand them out to you."

This is what we need in Australia instead of so-called "Political Correctness". Let's just get back to the good old fashioned values. It's time this "Political Correctness" garbage was thrown in the bin where it belongs.

We are ONE PEOPLE – ONE NATION – Australia, it's not that difficult!

JUSTICE OR A WITCH HUNT?

by

Dr Mal Mohanlal

It seems that the High Court of Australia has vindicated my stance on Dr Jayant Patel in my article on "Consumer Laws and Doctors" in RDMA Newsletter, September 2010.

Dr Patel should not have been tried and convicted of manslaughter. It was a wrong charge and I clearly stated that the medical profession should have expressed strong outrage and objection to such a charge. But shame on us, we did not. There was not even a whimper.

Now it seems that the witch hunt is going to continue in the name of justice being seen to be done. Millions of dollars are going to be spent and wasted to satisfy the anger of a lynch mob. What good is this going to do to the doctor or the victims is really of no concern to the myopic and incompetent bureaucrats trying to save their own face? If this is not a travesty of our justice system, what is? As a profession, where do we stand on this issue? Are we just going to sit and watch one of our colleagues being crucified? As a profession should we not be expressing our moral and ethical point of view on this issue?

Somehow I liken the medical profession to an elephant which thinks it is clever but is not. It is a clumsy animal which the clever mahout (the government) knows how to manipulate. Consumer laws have mesmerised and blinded this poor beast to such an extent that it does not know its own strength and does not know how to use it. It will do whatever the mahout (the government) dictates.

When consumer laws are applied to medicine, the doctor is treated in the same way as a motor mechanic. That is, the consumer (the patient) sues the motor mechanic (the doctor) for faulty repairs (failed surgery).

However, repairs job done on a car is entirely different from a repairs job done on a human body. Why? This is because while the job done on the car is entirely dependent on the human element from manufacture to parts and repairs, the job done on a human body is mostly if not entirely dependent on the person's own healing power and not the doctor.

It must be pointed out to the lawyers and the public that no two individuals are alike when it comes to the healing process. There are physical and mental factors involved. Identical surgery on two separate individuals can have two different results. One may develop a big scar and the other patient may show hardly any scar. It all depends on the person's immune system and the genetic makeup. The strength of this immune system is dependent not only on the physical fitness of the person but also his or her mental state and age.

So if a person is anxious, depressed, miserable and old, this will affect his immune system and thus the healing and recovery process. What we as doctors do is try to provide the right conditions so that Mother Nature can heal the patient. However, if for some reason the patient's immune system shuts down, no doctor in the world can save that person.

In my mind I cannot see how a doctor involved in a medical mishap, should ever be charged with manslaughter when his or her main motive was to help the patient overcome his or her medical condition.

If society wishes to compensate victims of medical mishaps we have to have separate laws under which doctors can operate without being treated in the same way as a motor mechanic who has done a faulty job. Do our medical leaders understand this and will they take this matter up with our legislators?

If the medical profession does not take any active steps to have these unfair consumer laws changed, one does not have to be a prophet to predict a repeat of Dr Patel's case in the future.

Present laws just make doctors sitting ducks waiting to be shot. Are we going to take a firm stand on this issue and support the High Court judgement or are we going to just sit and watch the tragedy unfold?

Narangba Family Medical Practice

Job Vacancy

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

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

Contact: Dr Peter C. Stephenson, Mobile: 0403 151 602.

Practice Location: 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

Redcliffe ULTRASOUND

Moving forward to meet the Ultrasound needs of the Peninsula Community

I would like to thank you for your support during the past 2 years. We at Redcliffe Ultrasound have always prided ourselves on providing you and your patients with the best possible care, short waiting times and image quality. With the growth we have experienced since opening we have reviewed how we currently operate to ensure our continued services as well as increasing the range of services in the near future.

To facilitate this I am very pleased to announce I have entered into a partnership with a strong healthcare company that will allow me to expand our services to you and your patients whilst still maintaining our level of service. There will be a number of positive changes during the coming weeks the most exciting being that local Radiologists Dr Himanshu and Dr Suddy MacKechnie will be working with me. With their support we will ensure that you receive a timely report and follow up for your patients.

Other great changes will include the introduction of an integrated appointment and reporting system. The most exciting element of this is Medway, a system that allows you to see your patient's images almost as soon as they are done.

In the next month we will also start operating a second ultrasound room with the latest state of the art Phillips IU22. With the new partnership also comes the ability to offer other modalities.

Thanks again for your support and I look forward to continuing and building our relationships. If you have any queries, please feel free to call either myself or Tracey on 3283 3997

Kind Regards

Roslyn Savage

Banksia Beach MEDICAL

PTY LTD
ABN 19 152 004 807
Shop 15, 25 Sunderland Drive
Banksia Beach 4507

Ph: 34086822 Fax: 34086833

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Onsite Pathology, Physiotherapy and Psychologist.

Please contact Dr Patrick Tomasiello.

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Don't forget to email your articles and graphics to me for inclusion in our monthly RDMA Newsletter.

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MAKING THE BEST USE OF GPs IN EMERGENCIES AND NATURAL DISASTERS

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012

AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012

The AMA today released two new Position Statements outlining the role of GPs in emergencies and natural disasters and how best to support GPs in these situations.

The AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012 has been developed to help policymakers at all levels of government and medical practitioners across Australia be more aware of the issues involved in natural disaster planning and emergency management, and the role of GPs in these situations

The AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012 is aimed at helping those involved in planning the immediate recovery from a natural disaster or emergency to focus on the needs of general practices in the immediate aftermath of such events.

AMA President, Dr Steve Hambleton, said today that GPs are at the forefront of providing care in a crisis.

"When a crisis hits and there are injuries, GPs and other doctors make themselves available to see their patients, patients not able to see their own doctors, backfill positions in hospitals, provide on-the-ground assistance in emergency locations and in emergency accommodation, and they treat the walking wounded – both the rescued and the rescuers

"We saw this recently in the Queensland floods and the Victorian bushfires.

"Despite this strong record of volunteerism, the role of GPs in emergency response situations is not well understood by governments, and GPs have not had enough input into disaster planning.
"The AMA would like to see a more formal process of involving GPs in planning for emergency or disaster situations.

"We also want to see coordinated planning to ensure that primary health care services remain active in the aftermath of disasters, including when GPs, their families, and their general practices are victims of natural disasters," Dr Hambleton said.

The AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012 is at http://ama.com.au/node/8162

The AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012 is at http://ama.com.au/node/8167

13 September 2012

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

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.

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription due for the period: 1st July 2012 to 30th June 2013

Dear Doctor

The Redcliffe and District Medical Association Inc. have 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 2012 your subscription to cover until the 30th June 2013 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. Suggestions on topics and/ or speakers are very welcome.

Please can you endeavour to pay your subscription by internet banking as it is so much easier for all concerned as it saves 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

ABN 88 637 858 491

1. **One Member (July to June: $100; Oct.-June: $75; Jan-June: $50.00; April-June: $25.00)**
2. **Two Family Members ($25 Discount each) ($150 pro rata)** (Please supply details for both members)
3. **Doctors-in-training and retired doctors: free**

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

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

1. ***EMAIL ADDRESS***: _____@_____

2. ***EMAIL ADDRESS***: _____@_____

Practice Address: _____ Post Code: _____

Phone: _____ Fax: _____

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

METHODS OF PAYMENT:

1. **PREFERRED** **INTERNET BANKING**
2. **PAYMENT BY DEPOSIT SLIP**: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. **ENCLOSED PAYMENT:** (Note: Member Subscription Form on website for you to type directly into and email)
   i) **Complete form & return: c/-QML or Redcliffe & District Medical Assoc Inc. P O Box 223 Redcliffe 4020**
   ii) Or by email to GJS2@Narangba-Medical.com.au

Where We Live And Work

Woodford