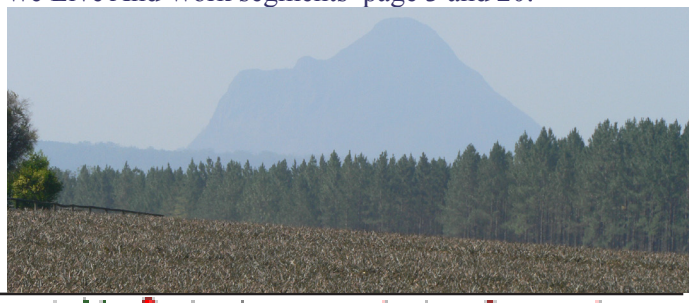
RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
DECEMBER 2012

http://www.pinkfrosting.com.au/shop

Elimbah

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



RDMA President's Message ... Dr Wayne Herdy

I am an optimist. My glass is always at least half full and still counting. Every challenge is an opportunity,

The AMA lives in a world that is mostly pessimistic. Bad news on every front, attacks from the powerful but ill-informed, from the noisy eccentric and ignorant minority viewpoints.

RDMA lives in a much smaller world than the AMA – we are a local medical association. Even though our President and Vice-President are AMAQ Branch Councillors and we use them to keep in tune with the big state and national issues, we focus on a smaller medical environment. So what are going to be the big ones for RDMA in the coming year?

The whole concept of GP Super Clinics is fundamentally flawed, and few examples are as flawed as the Redcliffe GPSC. It was barely off the drawing board when it had blown its budget and needed a rescue package bigger than its original grant just to avert legal action by the building contractor. Its real opening date is in the same province as next week's winning Lotto numbers. And there is still nary a GP in sight, let alone anything that will promote primary care in proportion to the cost of this magnificent white elephant.

The Newman government razor gang has slashed budgets, albeit with some sparing of the QHealth budget. Few sensible people would deny that the slashing is necessary to avert a State bankruptcy. However, our challenge is to guide the belt-tightening so that unnecessary administrators are carved off while hands-on clinicians (not only doctors) are left to provide direct patient services.

I expressed concern a year ago that the Medicare Local (a term that is under review as the government reluctantly accepts it to be a monumnetal misnomer) would remain focussed on the larger metropolitan areas while neglecting the poorer country cousins out at Caboolture and further. I have not yet seen any evidence that my fears are not going to be a valid prediction.

This year sees a workforce crisis born of the rapid increase in graduate numbers. There are just not enough training places to teach the new doctors. Hundreds of graduates face unemployment. Apart from the question that there is a moral obligation to guarantee career pathways, the rapidly growing areas at the fringe of Moreton Bay Regional Council have a need for increased numbers of graduates to service the expanding population.

Challenges, not threats – so lets get to work on the local issues in the next year.

Wayne Herdy

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

2013 MEETING 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

Tuesday February 26th
Wednesday March 27th
Tuesday April 30th
Wednesday May 29th
Tuesday June 25th
Wednesday July 31st

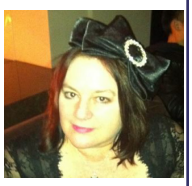
Annual General Meeting
Tuesday August 27th

Wednesday September 18th
Tuesday October 29th

End of Year Networking Function
Friday November 29th

CONTACTS:

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



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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
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Mobile: 0408 714 984

FEBRUARY NEWSLETTER 2013

The 9th February 2013 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com
Website: http//www.rdma.org.au

INSIDE THIS ISSUE:

Elimbah

Elimbah is a suburb in Queensland's Moreton Bay Region located north of Caboolture, and south of Beerburrum. In the 2011 census, the suburb recorded a population of 3,713 persons. Elimbah's railway station is located in the suburb serviced by Queensland Rail's City-train services on the Nambour and Gympie North railway line.

The area was known to the Kabi people, the original inhabitants before European settlement, as the place of the grey water snake "Elimbah", hence the creek was named Elimbah. Elimbah's township was named after Elimbah Creek. The teamsters knew it as The Six Mile, a place to camp and rest their horses or bullocks. But when the railway came through in 1890, the rail stop was simply known as '36 miles 68 chains' apparently because that's the length of railway when measured from Brisbane. Urged by local residents it was officially named Elimbah on the 20 September 1902.

Elimbah's modernised railway station stands prominently on the existing railway line running northwards out of Brisbane. Commuters to Brisbane or the Sunshine Coast enjoy a relaxing air-conditioned mode of transport which is one of the most common reasons for trains stopping in Elimbah. The township is surrounded by turf farms and other primary industry crops include the popular seasonal pineapples, strawberries and melons which are also transported to produce centres for sale locally or statewide.

Elimbah is bounded by the Sunshine Coast Council area in the north. The Pumicestone Channel and the locality of Donnybrook is the boundary in the east. The locality of Caboolture, Pumicestone Road, Emu Road, Kirby Road, Old Gympie Road, Field Road and Alcock Road are the boundaries in the south. Boden Road and a line joining Boden Road and Williams Road, Williams Road, Twin View Road and the locality of Woodford is the boundary in the west.

Settlement of the area dates back from the 1890s when the railway line was constructed but significant development did not occur until the late 1980s. Rapid growth did eventually take place from the early 1990s, with the population quadrupling between 1991 and 2006. This population growth has continued steadily to current times.

Elimbah Village is approximately 8 km north of Caboolture, situated on the Beerburrum Road at the point where the road crosses Six Mile Creek. It's the local heart of a rural community that is rapidly subdividing itself into a rural-residential suburb of Caboolture and Brisbane, primarily because of its excellent transport links to both Brisbane and the Sunshine Coast. Brisbane is an hour by train or 45 minutes road trip via the Bruce Highway.

The village consists of a Service Station and the local shops include a Newsagents, Hairdressing Salon, Bakery, Builder's outlet and a New Age Holistic Shop. Elimbah also has a Pre-School, a State School, a Uniting Church and Elimbah's Soldiers Community Hall, a vendor of Agricultural Supplies. The majority of this infrastructure is situated on the western side of the railway line, along Beerburrum Road with the Elimbah Sports and Recreation Ground on the eastern side of the railway line.

Major features of the area include Glass House Mountains National Park, Beerburrum East State Forest, Beerburrum West State Forest and Morris Park. There is an opportunity for a leisurely climb of the southernmost volcanic plug of the Glasshouse Mountains, Round Mountain. Round Mountain is situated on Timbergrove Road off Old Gympie Road. Travel south from Elimbah village and cross the bridge over Six Mile Creek, take the first right onto Smith's Road and keep going until shortly after the road sweeps around left into Old Gympie Road.. Scenic pine forests dot the horizons.

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT
Dr ALEX MARKWELL

Update from AMAQ President

As you may be aware, the Health Minister has asked the Auditor-General to undertake an audit of the different private billing practices within Queensland Health. This review will be looking at processes and identifying areas for improvement which can be clarified.

AMA Queensland does not believe the Auditor-General will be undertaking specific investigations of individuals but may refer specific cases of potential illegal activity to the CMC for investigation, as is appropriate. At this stage, AMA Queensland is not aware of any substantiated allegations but we endorse the full and appropriate investigation of any inappropriate or illegal dealings.

AMA Queensland is keen to ensure there are consistent and transparent billing practices in place and as such, we support this review of processes to ensure that patients, doctors and administrators have confidence in the system.

The current debate around public hospital billing procedures is also a timely opportunity to remind AMA Queensland members to be aware of their rights and responsibilities regarding Medicare billing in Queensland Health hospitals. For more information, visit the AMA Queensland website www.amaq.com.au.

Recent weeks have also brought some updates on the ongoing shortage of positions for interns and junior doctors in 2013.

The Director-General has advised that Queensland Health (QH) will be funding an additional 18 interns to commence in 2013 in conjunction with the Commonwealth who will fund an additional 40 interns in Queensland in the private sector.

All 18 interns will be recruited from the pool of Queensland International Full Fee Paying (IFFP) medical graduates who have not yet received an intern offer for 2013. Queensland Health is also considering options for a return of service obligation from the 18 additional interns. The Commonwealth will most likely seek a return of service of one year from the 40 intern positions they are funding for 2013.

There are currently 76 priority four candidates who have not yet been offered an internship with Queensland Health for the 2013 clinical year. Priority four candidates are medical graduates of Queensland universities who are overseas permanent residents or overseas citizens, other than New Zealand citizens and are permitted to remain in Australia for internship.

As of the end of November, there were still 209 junior doctors who were currently employed by Queensland Health who had not received job offers for 2013. HHSs are still finalising their recruitment of junior doctors for 2013 and the Director-General has encouraged them to provide *Letters of Good Standing* upon request to junior doctors who are unsuccessful in securing positions for 2013.

There may still be some further opportunities via flexible work options such as job-sharing and part-time positions and potential positions in regional areas, such as where locums are currently appointed. Again, we have asked for HHS Boards to be made aware of the availability of these doctors in training for these positions where appropriate.

We will continue to update members as information becomes available via our website www.amaq.com.au. Please contact our membership team if you have any further queries membership@amaq.com.au

These challenges will carry over to the New Year but AMA Queensland is committed to supporting doctors and will continue to voice our concerns on behalf of members.

I would like to take this opportunity to thank you for your ongoing support and wish everyone a safe, healthy and happy holiday season.

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

Medicare eligible MRI scans now available at Qscan Redcliffe

Qscan Radiology Clinics are proud to announce that our Redcliffe MRI scanner now has a full Medicare license.

All Specialist referred MRI scans will now be bulk billed.

All General Practitioner referred paediatric MRI scans that fit Medicare criteria are also bulk billed.

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North Lakes 4509
T (07) 3345 4455

RDMA Networking Meeting (7pm) 30.11.12

Hosted by Vice President Kimberley Bondeson , Speakers Drs Paul Campbell and Chris Davis MP, Sponsored by QML Pathology, New Venue: Mon Komo Hotel,

AMAQ BRANCH COUNCILLOR REPORT

North Coast Area Representative
Dr WAYNE HERDY

Opportunities Awaiting 2013

I am an optimist. My glass is always half full and still counting. My spectacles have a distinct rose hue.

The AMA works in an environment that fertilizes pessimism. We are always battling somebody who wants to fix a machine that isnt broken, for reasons based on ideology more than logic and rarely truly based in the sort of evidence that we try to find in medical decision-making. Worse, the parties that we battle are often better resourced and more powerful, and argue strongly from positions of ignorance.

The AMA relies on enthusiastic but skilled amateurs, backed by a small cadre of equally enthusiastic and skilled paid soldiers, whose most powerful weapon is the truth.

Looking into the misty crystal ball that depicts the coming year, we can see workforce imbalance and lack of adequate training places, a shrinking health budget in relative terms, increasing scope-of practice debates with a horde of wannabe-doctors, blind political ideology that drives unproven or disproven interventions such as 4-year-old health checks and Medicare Locals, and the unsolved crime of social inequity that we interpret as a 17-year gap in indigenous health outcomes.

This is in a global environment of still-incomplete financial meltdown and climate change which have their own direct and indirect health outcomes. As well as our political opponents, we are facing increasingly powerful biological opponents such as an explosive obesity epidemic and the looming end of the antibiotic era.

Despite all the old and new threats, remember that every threat is a challenge, an opportunity in disguise. While I mourn the demise of the solo practitioner, I welcome the evolution of team-based medical care. While I bury the vestiges of trusted ancient remedies, I embrace the science of evidence-based medicine that systematically proves that most of what I ever learned and did was wrong.

While I shudder at the legal vultures hovering over every move I make and the bean-counting gnomes that measure every dollar cost that I incur, I welcome the outcome that medical interventions are forced by external influences to become safer and more efficient.

The coming year promises escalation of the warfare with our old enemies, and the probability of new enemies creeping up from left and right field. But the medical profession is an ancient and wise one, and we eventually respond by becoming stronger and more effective champions of the health outcomes for our patients.

Next year will be even fuller of challenges than the last year was – let's turn every one of those challenges into an opportunity to win battles for better health outcomes.

Wayne HERDY
AMAQ Branch Councillor.

RDMA VICE PRESIDENT & AMAQ COUNCILLOR REPORT
Dr KIMBERLEY BONDESON

Networking Meeting and Questions for 2013

The Christmas party at Mon Komo was thoroughly enjoyable. Trialing a new venue was an experience which was enjoyed by all.

The only criticism was competing with the music downstairs. This did not take away from the quality of the talks and their associated question and answer sessions which were well participated in and enjoyed by all.

We had two excellent guest speakers, Dr Paul Campbell, Allergist and Clinical Immunologist from North Lakes, and Dr Chris Davis, Member for Stafford, and the Assistant Minister for Health.

Dr Campbell is based in Coffs Harbour, with weekly allergy clinics in North Lakes. He gave a concise presentation on Mammalian Meat Allergy which was fascinating. In question time it was particularly illuminating as to the theory behind why some patients experience an anaphylactic reaction to certain types of anti-cancer treatments, eg. Cetuximab.

Cetuximab is a recombinant epidermal growth factor monoclonal antibody approved for treatment of metastatic colorectal and head and neck cancer. Infusion reactions are more prevalent in South Eastern United States and is thought to be related to other factors which include red meat diet and exposure to tick bites. (Saleh et al.Clinical & Molecular Allergy 2012 10:5).

We wish Paul all the very best with his new endeavour at North Lakes which is certainly offering a much needed service to the area. Dr Davis attended with his wife Dr Kate Sinclair, who works as a Paediatric Neurologist at the Royal Children's Hospital. Dr Davis is a former Geriatrician who worked at the Prince Charles Hospital for 20 Years and AMAQ past president. He was able to reinforce his stance and representation for the Stafford electorate and the Royal Children's Hospital, stating that Brisbane and Queensland could support 2 territory referral Children's Hospitals.

We are now looking forward to 2013 - a new year and let's hope a better one. There are still some questions left over from 2012:

1. Will the Superclinic at Redcliffe ever be open? Will it ever have any GP's in it?

Or will it evolve into a 'General Purpose' building as one of my patients suggested?

2. Why is Queensland Health continuing to throw good money after bad into the QHealth payroll debacle? Latest update is an inquiry costing 5 million dollars, so they can find out who is responsible and 'blame someone'.

I thought it was just a poor IBM computer program that did not work. It overpaid, underpaid, and did not pay. Even a long term employed RN at Dysart in Central Queensland got paid as a groundsman in error (the nurse occasionally did extra shifts cleaning at the local community centre in an adjoining small town). She still can't understand her payslips.

Merry Christmas and a Happy New Year to all. Kimberley Bondeson

SNAPSHOT FROM THE PAST LMA Urges Review of Skin Clinics

REDAMA Newsletter from Series 2 No 7 December 1990, page 11

LMA urges review of skin clinics

Redcliffe and Districts Local Medical Association has urged the Queensland Cancer Fund to review its criteria for locations used in Skin Cancer Awareness Clinics.

The suggestion follows the clinic held at Scotts Beach bathing pavilion on November 25 to mark the completion of Skin Cancer Awareness Week throughout Queensland.

Nine members of the LMA volunteered to staff the clinic between 8am and 12 noon and provided a service to almost 100 people.

However, co-ordinator, Dr Bob Brown, believes the clinic was in the wrong position at the right time.

Early expectations had been for the clinic to attract thousands of people because it was held at the same time as a junior triathlon and a yachting regatta.

But the vast majority of spectators finished up at Suttons Beach which had been rejected as a site for the clinic because it did not have facilities to meet the Cancer Fund's pre-determined requirements.

These were a covered pavilion and a power source.

In a letter to the Fund, Dr Brown has said that while acknowledging the financial restraints involved, he believed a free standing structure such as a tent, with a power generator would provide the same facility.

He said it would up up venues such as Suttons Beach for skin cancer clinics which were obviously popular with the general public as awareness of the dangers became more widespread.

Dr Brown complimented the LMA members who volunteered their services for the clinic "on a precious Sunday morning."

They were the president, Dr David Brand, and Doctors Bruce Flegg, Bruce Hansen, Mal Mohanlal, Peter Knapp, Larry Gahan, Peter Stephenson and Bob Brown.

The HODGE REPORT

AT THIS time of year, you are obviously as busy as I am but my report, although not as comprehensive as usual, in no way reflects the amount of activities undertaken by the association in the past month.

I want to touch on the meeting between the A.M.A. Executive and the Health Minister's Committee.

We have also completed submissions on Medical Manpower and to the Public Sector Management Commission's (P.S.M.C.) review on Medical Practitioners in the Legal System.

I have included a brief overview of those submissions.

We are also vigilant in our efforts to monitor government policy and persistent in our attempts to have input into legislation where it affects doctors.

Our submission to the P.S.M.C. on Medical Practitioners in the Legal System emphasises the disruption of patient care and the hospital medical environment by a doctor being required to appear as a professional witness.

We also point out that fees provided to doctors for those services do not cover the actual costs of running a practice.

The fees available for normal medical services and for matters before the civil courts compared to those available for the services of G.M.O.s and matters before the criminal courts have widened so considerably as to be a major disincentive to undertaking G.M.O. duties.

Recommendations made in the submission include:

- That fees for professional witnesses be adjusted to a realistic level and at least cover the practice overheads of private practitioners.
- That fees for medically-qualified Crown witness for court appearances be those recommended by the A.M.A. Queensland and that fees be applicable to all court appearances irrespective of the type of court.
- That provision be made for fees for appointments, cancellations and deferments as well as a fee for all reports, irrespective of the type of court.
- That court procedures be reviewed to minimise appearances by medical witnesses.
- That a committee be established to examine and recommend the terms and conditions of service of G.M.O.s.

As with all submissions, if you are interested in reading the full text, you can phone the Secretariat and a copy will be sent to you.

Medical manpower is a matter of ongoing concern and the cause of much debate.

We have made a submission to the Federal A.M.A. which included the views of many colleges and groups in Queensland.

The essential content of our submission is that while we recognise the shortage exists in some medical disciplines, the main problem lies in the unsatisfactory distribution of medical practitioners.

PLEASE NOTE

Redama Report will not be published in January. The next edition will be published on February 14, 1990. Deadline for advertising bookings and copy, and editorial contributions will be February 7.

REDAMA REPORT

Redama Report is the official publication of the Redcliffe and Districts Local Medical Association, and is distributed free to members of the medical profession in the association's designated area.

Editor: Ross Thompson, Gold Coast Word Factory Public Relations, PO Box 114, SOUTHPORT 4215.

Telephone: (075) 91 3099 Fax: (075) 91 3216.

MAJELLAN MEDICAL CENTRE

Job Vacancy

A VR, GP is required for a Scarborough Beachfront, Non-Corporate Practice which is 30 minutes from Brisbane's CBD. The Accredited Practice has private billing facilities, modern equipment and has staffing of nine doctors and registered nursing support.

The Medical Centre has a Computerised Skin Cancer Clinic, ultrasound machine and operating microscope. Allied Health staff are also on site. A candidate who is fluent in English, Afrikaans, Dutch, German or French languages would be an advantage.

Contact: **Angela De-Gaetano (Practice Manager)**
Practice Location: Majellan Medical Centre, 107 Landsborough Avenue, Scarborough Q 4020
Practice Phone: (07) 3880 1444 **Practice Fax: (07) 3880 1067**



Interesting Tidbits NATTY MOMENTS:

OLD AGE SERENITY

Just before the funeral services, the undertaker came up to the very elderly widow and asked, 'How old was your husband?' '98,' she replied. 'Two years older than me'.

'So you're 96,' the undertaker commented. She responded, 'Hardly worth going home, is it?

Reporters interviewing a 104-year-old woman: 'And what do you think is the best thing about being 104?' the reporter asked. She simply replied, 'No peer pressure.'

The nice thing about being senile is you can hide your own Easter eggs.

I've sure gotten old! I've had two bypass surgeries, a hip replacement, new knees, fought prostate cancer and diabetes. I'm half blind, can't hear anything quieter than a jet engine. I take 40 different medications that make me dizzy, winded, and

•subject to blackouts, have bouts with dementia
•have poor circulation;
•hardly feel my hands and feet anymore.
•can't remember if I'm 85 or 92.
•have lost all my friends.

But, thank God, I still have my driver's license.

I feel like my body has gotten totally out of shape, so I got my doctor's permission to join a fitness club and start exercising. I decided to take an aerobics class for seniors. I bent, twisted, gyrated, jumped up and down, and perspired for an hour. But, by the time I got my leotards on, the class was over.

My memory's not as sharp as it used to be. Also, my memory's not as sharp as it used to be.

Know how to prevent sagging? Just eat till the wrinkles fill out.

It's scary when you start making the same noises as your coffee maker.

These days about half the stuff in my shopping cart says, for fast relief.

THE SENILITY PRAYER :

Grant me the senility to forget the people I never liked anyway. The good fortune to run into the ones I do, and the eyesight to tell the difference.

Always Remember This: You don't stop laughing because you grow old, you grow old because you stop laughing!! Not that any of us are old !

MEDICAL MOTORING
with Doctor Clive Fraser

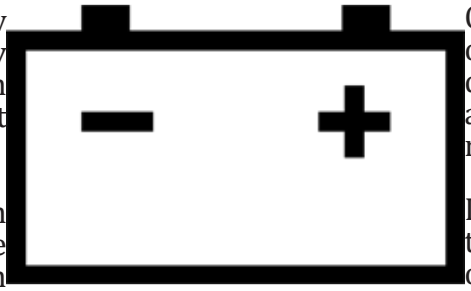
Motoring Article #98
Safe motoring,
doctorclivefraser@hotmail.com.

Lead Acid Batteries "Start Me Up"

It is no secret that modern cars are packed with electronic gadgets.

MP3 players and satellite navigation are in our pockets and most of us also want them on the road.

Advances in mobile battery technology have meant that these portable devices will keep working for longer and longer, but there really hasn't been anything new in lead-acid battery technology since French physicist Gaston Planté invented the world's first rechargeable battery in 1859.



It seems that there isn't much you can do to enhance the chemistry of putting lead in contact with sulphuric acid.

And no matter how you do the sums, you'll never get more than 2.1 Volts from each cell.

Capable of only about 800 cycles it's a fact of life that most lead-acid car batteries are lucky to last any more than three years.

So with my own car only two years old I was becoming anxious about my starter seeming a little slower to turn over and then with the next start there was nothing, or at least only the faint sound of my starter motor and then nothing.

It was at that point that I discovered that my car had some artificial intelligence rivalling Hal from 2001: A Space Odyssey.

You see one of the features of my frameless car doors is that the battery does have to supply the electric windows with enough current to lower the glass a fraction of an inch to clear the door rubbers every time the doors open, and close.

Though there wasn't enough power to start my car there was enough to bring the windows down, save for the fact that I might find myself trapped in my car and unable to exit.

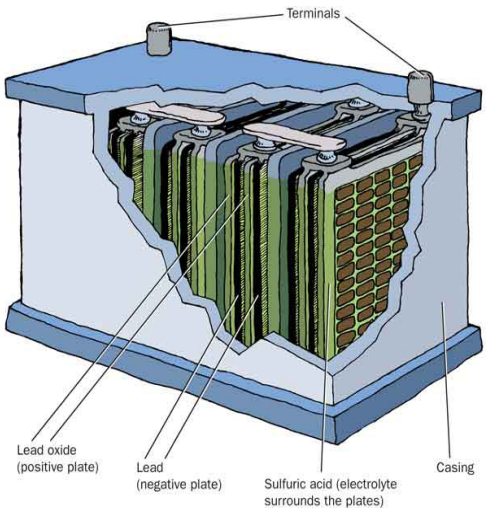
The only problem was that every time I tried to turn the motor over, my windows (all four of them) kept descending.

By the time I'd given up any hope of getting home without assistance the windows were all the way down which did make me wonder how I would have fared if it was raining or how I would have locked my car if I had to leave it.

One other interesting epiphenomenon of having a flat battery was my car's decision to disable my air-bags, but as I wasn't going anywhere did that really matter?

I was relieved to get going again with the assistance of my local motoring organization, but that pesky air-bag warning light stayed on and I still needed a visit to my local dealer to extinguish it.

The bad news here is that there really was no warning that my battery would suddenly fail and I'm not sure why any motorist should have to go back to their dealer after simply suffering a flat battery.



The good news was that my battery was covered by my new car warranty so I didn't have to pay for the parts and labour to get mobile again.

Automotive lead-acid batteries

For: Capable of providing huge surge currents for starting.
Against: Heavy and environmentally unfriendly.
These batteries would not suit: Defibrillators or pacemakers.
Specifications:
- 2.1 Volts per cell
- 6 cells provide 12.6 Volts
- Charging forces electrons from the positive plate
- Specific gravity falls as the battery discharges
- Fully charged specific gravity is 1.265 g/cm3
- Fully discharged specific gravity is 1.120 g/cm3

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

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

BELLARA FAMILY MEDICAL PRACTICE

BRIBIE ISLAND, QUEENSLAND

Job Vacancy

A General Practitioner Position is available at the Bellara Family Medical Practice on Bribie Island, Queensland. An opportunity for a fulltime VR GP to join our long established General Practitioner owned seaside practice is available.

The Accredited Practice is fully computerised and offers mixed billing. We have an excellent supportive team of Doctors, Registered Nurse and Administration staff. We offer family friendly hours with no on-call duties.

Practice Contacts: Trish Jackson (Practice Manager) or Dr Jai Raj
Practice Manager Phone: (07) 3408 9077 Dr J Raj Mobile: 0418 714 183
Contact Email: jraj@ozdoc.com.au
Practice Location: Bellara Family Medical Practice, 35 Benabrow Ave, Bribie Island Q 4507

REDCLIFFE HOSPITAL EXECUTIVE DIRECTOR REPORT
Dr DONNA O'SULLIVAN

Clinical Pharmacy 7 Day Service Better For Patient Safety

It's always exciting to be the bearer of good news and any announcement of service expansion to ensure continued quality and safe care for our patients is a bonus in the current climate.

At Redcliffe Hospital we've implemented important changes to our inpatient pharmacy practices to ensure patient safety. We've expanded our clinical pharmacy service from 4 November 2012 in the medical, surgical, intensive care and orthopaedic wards from weekdays to also include weekends and public holidays.

The pharmacist ensures every inpatient chart is monitored for basic clinical pharmacy activities such as drug supply, drug dosing, interactions, allergies and duplicate orders.

Additionally, when time permits the pharmacists will also focus on high risk patients to produce Medication Action Plans and medication histories.

These changes and service expansion are paramount to patient safety and ensures we meet industry best practice medication management standards.

Redcliffe Hospital secured over $1 million continued funding for the service expansion from Metro North Hospital and Health Service including three new part-time pharmacist positions.

There are plans to also expand the service to have a ward pharmacist in the Emergency Department (ED) commencing early 2013.

The changes were made in response to the Health Quality Complaints Commission (HQCC) final investigation report on a patient death for a medication overdose at Redcliffe Hospital in 2009.

If you would like more information, contact Derek Just, Director Pharmacy Services on 07 3883 7781 or email derek_just@health.qld.gov.au

As the festive season is upon us, here's wishing you all a very Merry Christmas and a safe and happy holiday. Enjoy the time with your loved ones.

I look forward to providing you with more updates in 2013 including ventures and prospects like the Moreton Bay Integrated Care Centre (Redcliffe GP Superclinic).

Dr Donna O'Sullivan
Executive Director and Director Medical Services

LETTER TO THE EDITOR

FROM

HAM ONG

As quoted at her centenary celebration, 'Dame Elisabeth Murdoch's public service and philanthropy has been wonderful, beginning with the Royal Children 's Hospital and the Murdoch Children's Research Institute.'(Melbourne)

We in Brisbane have a wonderful and important Royal Children's Hospital. It has saved many young lives, improved even more, and is a cherished institution.

We have been warned that it is going to close down and be replaced by the New Children's Super Hospital in the South Side of the river.

True we have not had the fortune of a great benefactor as in Melbourne.
But both Sydney and Melbourne have at least 2 major children's hospital. So it cannot be unacceptable to have at least one major Children Hospital for Brisbane, especially the Northside, as purported by some politicians.

To close our Royal Children's Hospital will disadvantage the whole population of Brisbane.

True that North of Brisbane residents will be the most affected. South side residents will also be disadvantaged by having to wait longer queues, face reduced services & parking facilities because they have to share it with their Northside neighbors whereas if RCH is still available, they will be much better off.

Northside residents will face the most difficulties.
As traffic conditions continue to worsen with time, crucial minutes can be lost by crossing the river in heavy traffic or bad traffic jam. If parents lose their child from not getting to the new hospital in time who will be responsible for this? Some politicians only listen when there is liability hanging over their heads.

The Royal Women's Hospital, with its newborn patients/neonates no longer has a facility in proximity for their very sick babies. Again time can be very crucial.

Expectant mothers from the Northside please speak up.

What will happened to the valuable and established research centre within the RCH?

To close RCH would be a great shame and disservice to the whole population of Brisbane and Queensland.

Please encourage all your colleagues, patients, relatives and friends to send a strong message to the government on this issue. Make them feel liable for implementing this stupid decision.

Yours truly,

Ham Ong

COMPUTERS & GADGETS

Email: apndx@hotmail.com.

with Doctor Daniel Mehanna

Electronics "Boot Me Up"

Welcome to my (first) electronics column. Just to give you an overview I recently joined the RDMA and noticed a great series of articles by Doctor Clive Fraser about cars and thought to myself -wouldn't it be great to write a column about one's passion something completely different and non medical!

Upon further thought, my rational side took over. My little voice muttered - you did science and maths at school (falling asleep during English classes), spent 6 years in medical school and years on top of that in further training….. What do you know about writing?

You're a doctor my little voice continued, not a writer. And so the idea was quickly relegated into the too hard basket...until I was approached by a Karen, a friend and work colleague who just happened to be the publisher of the newsletter and was seeking contributors. So I bit the bullet and said yes.

The next step was to decide the topic. For me at least it was a no brainer. That was the easy part as for most of my life I have been heavily involved in computers and electronics.

From my first computer, the Apple IIE to a "Lingo" (a "cheap" $3000 IBM clone) through to a multitude of PCs (Intel, AMD and Cyrix) of various types, capacities and sizes which I would build after hours of painstaking research into every component. More often than not I would delve into the black art of over clocking (who can remember the Pentium 300A that was so easily overclockable to 450Mhz!) occasionally ending up with a "bricked" or destroyed CPU unable to sustain the demands that I would inflict upon it.

From CPUs being measured in megahertz (remember the DX 2/66?) not gigahertz, from dialup modems being rated as 300 bits per second not megabits per second. How things have changed.

From the time before the internet when I would log onto a BBS (bulletin board system) using a dialup modem often for hours at a time (thank you Teltra for not introducing timed local calls!) to establish my credentials. I used to go by the handle "the blade" with some of my other friends going by names such as "zapatrax" and "ricochet". I would befriend the sysop (system operator) with the goal of gaining access to the hidden treasure trove of pirated software buried deep inside the BBS. Those were the days! But I digress.

Over the next months I hope to write about anything computer/ gadget orientated, from computers to smartphones and the programs that are used on them, to anything else in between.

I hope you enjoy reading it as much as I will enjoy writing about it. Please feel free to email me if you have any feedback.

regards Daniel Mehanna
Email: apndx@hotmail.com.

SCREENING TO PREVENT CERVICAL CANCER

By: Dr Archna Saraswat, FRANCOG, Gynaecologist, **North Lakes Day Hospital, contact 1300 780 138 or fax (07) 3054 0497.**

HISTORY Cervical screening became available for Australian women in the mid-1960s. The approach was opportunistic with no formal policies. An organised approach was introduced as a national strategy in 1991. A two-yearly cervical screening interval was nationally recommended and introduced for the target population aged 20–69 years. State and territory Pap test registries were developed which have now matured into functional units that are integral to the success of the screening program.

INCIDENCE About two million Australian women have a Pap test for cervical cancer screening each year. Australia has the second lowest incidence of cervical cancer in the world among countries with comparable cancer registration systems (GLOBOCAN 2002). From 1092 new cases in 1987 of cervical cancer in Australia the number declined to 745 cases in 2000. Of these 578 occurred in the target age group of 20–69 years. Cervical cancer incidence and mortality have declined in the target age group by 56.9% and 57.7%, respectively, over the past decade. The risk of dying from cervical cancer for an Indigenous woman is still about six times that of a non-Indigenous woman. The incidence of adenocarcinoma has remained unchanged.

EPIDEMIOLOGY AND RISK FACTORS CIN 1 is an infective process rather than a neoplastic one. Most HPV infections acquired by women resolve without medical intervention. HPV is necessary for development of cancer of the cervix . Over 99.7% of cervical cancers test positive for HPV DNA .The attributable risk to HPV is greater than the risk of lung cancer conferred by smoking. The point prevalence of HPV among sexually active young women is high at around 20% to 25% (Ho et al 1998). Repeated testing of teenagers over a three-year period has documented a cumulative prevalence rate of 44% (Woodman et al 2001). The modal age of diagnosis with cervical cancer in unscreened women varies between 35 and 50 years. Less than 0.2% of cervical cancers occur in women under 25 years(Burk et al 1996, Bosch and de Sanjose 2003, Sherman et al 2003a). This data suggests that progression of HPV infection to cancer is slow which is confirmed by longitudinal epidemiological studies.

Of the two main types of cervical cancer: squamous cell carcinoma and adenocarcinoma SCC is more prevalent. Both types are found in sexually active women. Of the approximately 30 to 40 HPV genotypes that infect the mucosa of the genital tract, eight (types 16, 18, 45, 31, 33, 52, 58, and 35) are responsible for 95% of cervical cancers, and two (types 16 and 18) are responsible for about 70% of cervical cancer. The probability of developing CIN 3 was 47.4% for women in whom two tests were positive for HPV type 16 infection, compared to a risk of 2.3% for women who had two negative HPV tests. Cigarette smoking increases the risk of cervical cancer up to fourfold.

THE PAPANICOLAOU SMEAR The PAP test aims to identify abnormal cells sampled from the transformation zone. Results are classified according to the Australian Modified Bethseda System 2004. Glandular abnormalities are found in approximately 0.1 to 2.1% of cervical cytology samples. A smear with AGC (atypical glandular cells) is associated with a premalignant or malignant lesion of the endocervix or endometrium in 10 to 40% of cases and should be referred for a colposcopy.

CHOOSING CONVENTIONAL SMEARS VERSUS LIQUID-BASED CYTOLOGY Choosing between conventional smears and liquid-based tests depends upon a variety of factors, including specimen adequacy, screening performance, ability to perform concurrent testing and cost. Liquid-based systems provide greater specimen adequacy, particularly for women with cervical bleeding or inflammation, which may obscure interpretation of a conventional PAP smear. Liquid-based and conventional smears appear to perform equally well for detection of HSIL, but liquid-based methods perform better for detection of glandular abnormalities, ASCUS and LSIL. The ability to obtain reflex HPV testing, when needed, from a single liquid-based specimen is another advantage of this technique.

ABNORMAL PAP SMEAR CIN encompasses a range of histological diagnoses. Women with LSIL have minimal potential for developing cervical malignancy. It often regresses and represents a self-limited infection with HPV particularly amongst young women. Those with HSIL are at high risk of progression to malignancy. The management goal is to prevent possible progression to invasive cancer while avoiding overtreatment of lesions that are likely to regress. The approaches can be of expectant versus immediate treatment.

The NHMRC recommendation for the first abnormal PAP smear with LSIL is to repeat the PAP smear in 1 year. A woman aged 30 years or more with a PAP test report of LSIL, without a history of negative smears in the preceding two to three years, should be offered either immediate colposcopy or a repeat PAP smear within six months. LSIL lesions will regress in most women. A retrospective study of 680 women with LSIL followed for one year found that 49% regressed to negative cytology or histology; 18% had persistent low grade cytology or histology; and 10% were subsequently diagnosed with HSIL.

Östör (1993) summarised all papers written over the preceding 40 years and calculated that 43% of CIN 2 regresses, 35% persists as CIN 2, and 22% progresses to CIN 3 over an undefined time period. 33% of CIN 3 regresses, 56% persists as CIN 3, and 12% progresses from CIN 3 to cancer, again over an undefined time period.

ROLE OF COLPOSCOPY Indications for Colposcopy are

- Repeat PAP smear after 1 year showing LSIL or HSIL. (If PAP smear normal then repeat in 2 years from the index smear)
- HSIL (possible or definite) on the index smear
- PAP test report of adenocarcinoma of endometrial origin or endocervical AIS
- DES-exposed women should be offered annual cytological screening and colposcopic examination of both the cervix and vagina.
- Postcoital bleeding with normal PAP result

If, at colposcopy, a HSIL is seen or suspected, targeted biopsy should be performed for histological confirmation before definitive therapy can be performed. 'See and treat' is not recommended. Women with a histological diagnosis of CIN 2 or CIN 3 should be treated by local ablative or excisional treatments in order to reduce the risk of developing invasive cervical carcinoma. The excisional treatments could be with the LLETZ or a cone biopsy. A woman previously treated for HSIL requires a colposcopy and cervical cytology at 4–6 months after treatment. Cervical cytology and HPV typing should then be carried out at 12 months after treatment and annually thereafter until the woman has tested negative by both tests on two consecutive occasions. The woman should then be screened according to the recommendation for the average population.

Evaluation of an abnormal Pap test during pregnancy or immunosuppression Women with LSIL should be managed in the standard way with a repeat smear after 12 months. Women with HSIL should be referred for colposcopic evaluation. If an immunosuppressed woman has a screen-detected abnormality she should be referred for colposcopy, even if the lesion is low-grade, as cytological surveillance alone may be inadequate.

VULVAR COLPOSCOPY Vulvar colposcopy is indicated in women with

- Visible abnormalities of the vulva
- No abnormalities of the cervix or vagina that can account for the abnormal cervical cytology
- Focal vulvar itch, pain or burning, without a clear etiology.

VAGINAL COLPOSCOPY Adenosis, pigmented lesions, and cysts

SUMMARY First LSIL report in a patient less than 30 years and with normal PAP in the last 2-3 years needs a repeat PAP in 1 year. A colposcopy is required for a persistent LSIL or HSIL result. Colposcopy is also required for repeated postcoital bleeding, vulval lesions or vulval itching. This escalation makes the screening program effective for timely intervention.

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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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AMA PROMOTES THE BENEFITS OF RELEVANT CLINICAL INDICATORS IN HEALTH CARE SETTINGS

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA Position Statement on Clinical Indicators 2012. The AMA today released a new Position Statement on Clinical Indicators. The use of clinical and performance indicators in health settings has been steadily increasing over recent decades.

Examples of clinical indicators in general practice include:

- The percentage of active patients aged 12–80 years who have a smoking status recorded;
- The percentage of active patients aged 15–80 years who have an alcohol status recorded;
- The percentage of sexually-active female patients aged 18–70 years who have been screened for cervical cancer.

AMA President, Dr Steve Hambleton, said today that the AMA recognises the potential benefits of clinical indicators. "The establishment of a mechanism that enables medical practices to regularly review robust and relevant information about their practice for the purpose of moving to best practice is essential," Dr Hambleton said.

"When used well, clinical indicators can form part of the suite of measures that lead to quality improvement and better outcomes for patients.

"Our Position Statement outlines how clinical indicators can be used to improve patient care.

"Clinical indicators must be relevant, evidence-based, and easily measured so as to ensure that limited resources are efficiently directed and that the data gathered is worthwhile.

"Clinical indicators that are not supported by evidence risk driving unproven and inappropriate clinical activity.

"When clinical indicators are not used well, they can lead to adverse consequences by focusing on the processes associated with measuring and reporting, rather than focusing on good patient care.

"The AMA believes clinical indicators should be independent of government and developed and ratified by the relevant medical speciality.

"The use of clinical indicators must remain voluntary and free of charge. They should be used for performance improvement and not used for penalties."

Quality improvement is the process of reviewing, refining and enhancing the processes for, and activities of, delivering patient care to mitigate risks and ensure better outcomes for patients.

In Australia, quality improvement in the health care system is also supported by:

- Continuing professional development;
- Accreditation of healthcare provider organisations;
- Federal Government funded practice incentives;
- The establishment of the Australian Commission on Safety and Quality in Health Care; and
- Audit and peer review processes such as that conducted by the Royal Australian College of Surgeons (RACS).

The AMA Position Statement on Clinical Indicators 2012 – which will be helpful to medical colleges, and other health professionals and policymakers considering developing or using clinical indicators – is available at https://ama.com.au/position-statement/clinical-indicators-2012

17 December 2012

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Kirsty Waterford 02 6270 5464 / 0427 209 753
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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.

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

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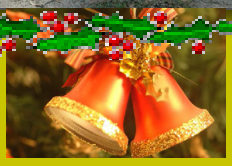

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