NEWSLETTER
February 2014

SCLMA President's Message .....
Dr Di Minuskin

Welcome back and a Happy 2014 to all. Christmas has come and gone for another year. My significant other, let's just call him Mr M, had a close call this year. Apparently he had bought me a new iron for Christmas. The week before the big day, he bumped into a friend and was explaining all the features of this top of the range appliance. As it happens, her husband is a jeweller. She convinced Mr M of the error of his ways, and suggested a visit to their store. Good advice!

Since our last newsletter, there has been a deluge of medical issues in the media. Some of these will be covered in other columns. I would like to mention just a couple of these here.

Co-payments for GP attendances. Whilst this is certainly not policy, it seems the government is dipping its toe in the water to test the community's and profession's responses. There are several proposals on how this would work. None of them is about improved health outcomes. The end point is cost. Whilst I acknowledge that it may be unsustainable to fund the current inflation rate in health costs, it is unfair to look to general practice solely for these savings. A key proposal of the co-payment scheme would be a freeze on MBS rebates for GPs until 2018.

The Productivity Commission report is strong evidence that GPs are already doing their bit. Since 2006, the cost for GP care per person has risen less than 1%. This is despite the fact that GPs are dealing with more complex consultations and more paper work. At the same time, the inflation rate for public hospital care is many times higher. Any measures that reduce access to primary or preventative care will only increase demands on hospital care in the future and thus, increase costs.

Another topic of interest has been the paper published in the MJA looking at the changing ratio of gender in students entering the UQ School of Medicine. Apparently the removal of interviews from the selection process resulted in the percentage of female students falling from 48% in 2008 to 26% in 2012. Surprise, young men are not as articulate as young women! The paper goes on to say that UQ are looking at ways of restoring the balance.

For fear of starting a gender war, I am going to remain silent on this issue, except to say, I would be more interested if there was some evidence as to whether this gender imbalance has an effect on health outcomes for the community.

Although I must point out that, if this trend continues, my male colleagues are going to have to dust off those speculums and start doing a few more PAP smears!

The new Sunshine Coast University Private Hospital has been up and running for a couple of months. The majority of the feedback I have had has been very positive. Some teething issues have surfaced and I thank those of you who have contacted me with concerns. Oli Steele, CEO, has been very helpful in pursuing these matters. He has offered to meet with the SCLMA regularly, so please continue to forward any issues you have for discussion.

There are further subjects that deserve attention such as the ongoing VMO/SMO contract negotiations, the push by insurance companies into primary care and the appointment of a nurse to the chair of the Queensland Medical Board. Our Editor gets stressed if I go over 700 words, although I hear the powder snow was great in Japan, so he might be a little more relaxed! Rest assured, your committee has been meeting behind the scenes and discussing these matters.

We have some great speakers lined up for 2014. The SCLMA is one of the largest LMA groups in the country. It has strong professional standards and fosters peer support and mentoring. We have many new doctors coming onto the coast and I would like to encourage them to come and join us, no matter what stage of their career. Membership renewals have been sent, along with a survey. Please return these promptly so we organise the year with your replies in mind.

Best Wishes, Di Minuskin

PS. The new iron works just fine! .....

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The Sunshine Coast Local Medical Association welcomes contributions from members, especially ***'Letters to the Editor".***

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MARCH NEWSLETTER Deadline Date for March 2014 newsletter will be FRIDAY 07 MARCH 2014

The Editor would like the newsletter to reach all readers in the 3rd week of each month. So ... ALL reporters and advertisers - please help us achieve this challenge!

Our circulation via email, post and courier (Sullivan Nicolaides Pathology) reaches approximately 800 recipients!

Contact Jo: 5479 3979
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We welcome new content - case studies, local news and photos. If you are a new member, send in a short bio and a photo to introduce yourself.

ARE YOU A MEMBER?

If you are not a member please complete the application form available on the website:

www.sclma.com.au.

You will need two proposers to sign your application form. If this is a problem, come along to a monthly clinical meeting to introduce yourself
Enquiries: Jo Ph: 5479 3979 or 0407 037 112
Email: jobo@squirrel.com.au

Are you listed on the Member Directory on our website? Are your details correct?

Directory form available on the website.

Editor's Corner ...

Welcome to February, welcome to Sochi, 2014 winter games.

It's all happening, snowboard cross, cross country skiing, ice hockey and so much more.

Russia glows in the glory; Sochi looks spectacular with the Black Sea lapping on one side and the snow-capped mountains on the other. The Russian Riviera frequented by oligarchs.

You may not understand my enthusiasm but having just returned from the powdery slopes of Hakuba, Japan, I have a relentless thirst for winter snow sport. So thank goodness that our LMA President Di Minuskin has prepared a very informative opening column highlighting all that's been happening over the Christmas break. It is an excellent piece of medical journalism and very quickly brings you up to speed with all the medical happenings on the Sunshine Coast.

On a commercial note thank you to all our sponsors again this year. Many of you have submitted refreshed advertising and I encourage all our readers to have a good flick through the newsletter to see all the new services available on the Coast.

To those fine dining buffs did you know that Tokyo has double the number of Michelin stars as New York and Paris combined? Francophiles and Yorkers eat that fact.

So know back to making that Ramen. (I will explain next time)

Time to run; it is the final of the giant slalom.

Bon Appetite

Marcel Knesl

mknesl@oceaniaoncology.com

HIGHLIGHTS:

SCLMA CLINICAL MEETINGS
6.30pm for 7pm (over by 9pm)

THURSDAY 27 February 2014

Speaker: Dr Jon Steinberg, Medical Director, Caloundra Private Clinic
Topic: 'Psychiatry Update - The DSM 5 and the new Caloundra Private Clinic'
Sponsor: Caloundra Private Clinic
Venue: Maroochydore Surf Club

THURSDAY 27 March 2014

Speaker: Dr Ian Baxter
Topic: 'Laparoscopic Obesity Surgery On The Sunshine Coast : What, Who, Why, and How Are We Doing?"
Sponsor: Shane Harvey, Covidien
Venue: Ebb Waterfront Dining.

ENQUIRIES: Jo Bourke
Ph: 5479 3979 (M) 0407 037 112
Email: jobo@squirrel.com.au

Meeting attendance:

- ***Free for current members.***
- ***Non members: $30.***
- ***Application forms available on night.***
- ***Membership forms also available website:***

www.sclma.com.au

HEALTH SERVICE LINK - FEBRUARY 2014
with Kevin Hegarty

As Di mentioned in her President's column in the December newsletter, the implementation of employment contracts for Senior Medical officers (SMOs) and Visiting Medical Officers (VMOs), is a focus within the public health sector.

Through a number of changes, including legislative, the Government and the Department of Health (DoH) have determined that all SMOs and VMOs will move from Award coverage to contracts of employment. There has been a period of consultation which was managed by the DoH.

The program for the implementation of the contracts has a required completion date of 30 April 2014. By that date, all SMOs and VMOs will need to have signed a contract in order to be assured of receiving all agreed remuneration components. Any contract, not signed as at that date, will result in the continuation of payment in accordance with the remaining components of the Medical Officers Certified Agreement 3 (MOCA 3). In essence, this will mean payment at a rate that excludes access and remuneration for private practice.

There has been significant consultation locally as to how the implementation of contracts will be undertaken. Given the devolved management structure within the Hospital and Health Service, we are well positioned to implement the new arrangements in a manner that is as much as possible clinician led. For example, the key performance indicators that are a central component of these contracts will be negotiated between the Clinical Directors of each specialty with the SMOs and VMOs involved in the delivery of that specialty within the HHS. There will be a guideline of the types of KPIs that will be expected to be evident across the HHS. These will cover such things as the need for KPIs that address patient safety and quality activities, together with KPIs that are linked to research and education responsibilities. We will also appropriately cascade throughout the organisation a number of the KPIs that the HHS is held accountable for by the DoH. Most notably the National Emergency Access Target (NEAT) and National Elective Surgery Target (NEST).

There are some provisions within the contracts that have attracted attention. Such as, the length of notice that needs to be given by either party if they wish to terminate the contract and the fact that some provisions of the contract may be varied unilaterally by the Director-General. These are very similar provisions to those that have existed for some time. The fact that they are stated in a contract has made them more visible. Overall, the contents of the contracts are similar to those found in most employment contracts for professional staff.

Our emphasis locally will remain on making sure that all staff are treated fairly and that employment processes are transparent and consistent. Given the very substantial recruitment challenge we have, as we grow our services in the lead up to the opening of Sunshine Coast Public University Hospital and beyond, to do anything other than behave in appropriate and considered way would be totally counter-productive.

Regards

Kev Hegarty
Health Service Chief Executive
Kevin_Hegarty@health.qld.gov.au

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AMA URGES QUEENSLAND DOCTORS TO REJECT DODGY CONTRACTS

Dr Steve Hambleton, AMA Federal President

AMA President, Dr Steve Hambleton, is urging all Queensland hospital doctors to reject Queensland Government contracts in their current form and is calling on the Queensland Government to return to the negotiating table in good faith to reach a fair and balanced agreement.

"The contracts are an insult to the professionalism and dedication of hardworking doctors and undermine the provision of quality medical care for the people of Queensland," Dr Hambleton said.

"Doctors feel like they are being forced to sign draconian contracts that strip basic employee rights and threaten their livelihoods. They are being put under enormous stress.

"The Government must end its 'take it or leave it' approach and immediately re-open contract negotiations."

Royal Brisbane and Women's Hospital Senior Medical Officers (SMOs) have rejected the unfair employment contracts, as have their colleagues in Cairns, Townsville, Mackay, Nambour, and Prince Charles Hospital.

Dr Hambleton recently attended the Medical Staff Association meeting at Royal Brisbane to hear the views of doctors affected by the contracts dispute.

"The overwhelming feedback from the meeting was that the contracts are unfair, unbalanced and will disadvantage all of the senior doctors currently working in the Queensland health system," Dr Hambleton said.

"The Federal AMA, AMA Queensland, the Australian Salaried Medical Officers Federation (ASMOF), and ASMOF Queensland are all hearing the same message from the coalface.

"The contracts currently on offer remove important employment rights and allow Queensland Health to make unilateral changes to contracts on a whim.

"These are good doctors who work around the clock saving lives and repairing damaged bodies. They are teaching and training the next generation of doctors to look after the patients of tomorrow.

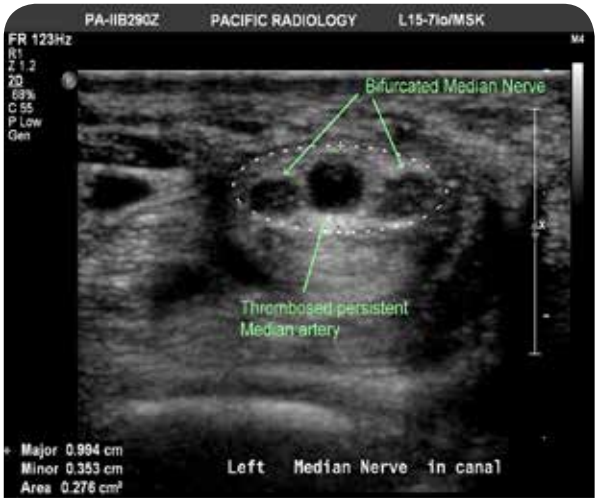
"The people of Queensland need and appreciate the specialised world class work of Queensland doctors. They want the confidence and security that these doctors will be there to help them when they or a family member are sick or injured.

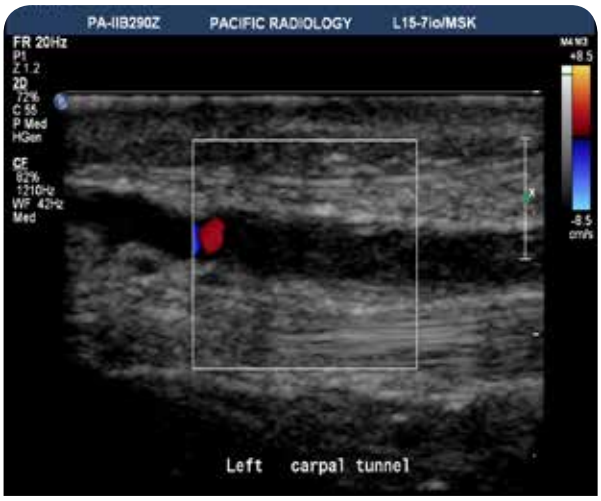
"The Queensland Government contracts are shattering that confidence and security," Dr Hambleton said.

CASE STUDY

Rare Case of Carpal Tunnel Syndrome Secondary to Thrombosed Persistent Median Artery.

Pacific Radiology





CLINICAL: 49 year old female presenting with ongoing wrist pain not relieved by pain killers. Mild paresthesia along radial side of the hand.

BACKGROUND: Carpal tunnel syndrome is a sporadically occurring abnormality due to compression of the median nerve. It is exceedingly rare for it to be caused by thrombosis of a persistent median artery.

IMAGING: High resolution ultrasound with Doppler examination revealed thrombosed persistent median artery with luminal dilatation. Associated bifurcated median nerve is visualised on both sides of the persistent median artery (Figure 1). The median nerve otherwise shows normal thickness and no hypoechogenicity, thickening or loss of fibrillar pattern.

Figure 1 (Left) – Cross section of persistent median artery with bifurcated median nerve on its either side [arrows].
Figure 2 (Right) – Longitudinal section of the persistent median artery with colour flow shows thrombus occluding the lumen which is mildly dilated, small amount of flow noted proximally).

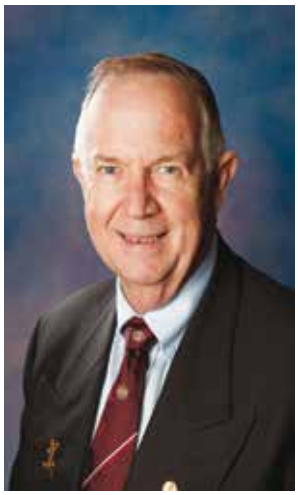
DISCUSSION: The carpal tunnel is bounded posteriorly by the arch of the carpal bones and anteriorly by the transverse carpal ligament. The median nerve and long flexor tendons of the forearm course through it from the forearm to the palm. The median nerve lies superficial to the flexor tendons and beneath the transverse carpal ligament. Conditions that crowd structures in the carpal tunnel such as tenosynovitis, ganglia, excessive fat or synovial hypertrophy may result in median nerve compression that may cause pain, paresthesia or sensory loss in the median nerve distribution and progressive atrophy of muscles of the thenar eminence. This is known as carpal tunnel syndrome, and is the most common entrapment neuropathy. Vascularity of the hand is extremely variable. A persistent median artery is one of numerous documented variations. A persistent median artery is present in approximately 10% of the population, and is almost always asymptomatic. Thrombosis of that artery to cause acute carpal tunnel syndrome is exceedingly rare. The mechanism is thought to be pressure from the thrombosed artery rather than ischaemia.

Described predisposing factors to thrombosis of the median artery include infection of deep fascial planes secondary to penetrating trauma, frequent bicycle riding with wrist placed in unusual position, stiff clutch of motorcycle, hormone contraceptive pills, screwdriver usage, excessive housework. In our case the patient admitted to having taken up recreational mountain biking before onset of symptoms.

Management includes medical treatment with anticoagulation in the early stages, hopefully leading to recanalisation of the artery. Surgery is performed if there is no improvement with medical management, and may include excision of the thrombosed segment of artery, or the artery may be dissected and moved away from the nerve.

AMAQ COUNCILLOR'S REPORT

Dr Wayne Herdy



MONOPOLIES are dangerous circumstances, because they rob the consumer of the natural protections afforded by competition. Queensland politics in 2014 are a monopoly. There is no Senate, no house of review in our unicameral Parliament. With Campbell Newman boasting an unprecedented majority after his electoral landslide, the "Opposition" can meet in a telephone box and is totally powerless.

In this dangerous environment, the Queensland government has sent an unmistakeable message to the medical practitioners of Queensland – our way or the highway. This government has the power to bulldoze its way through gentlemanly negotiation and has bullied the medical profession especially. Three clear examples are the Health Ombudsman, the QHealth contracts, and the newly appointed Medical Board of Queensland.

THE HEALTH OMBUDSMAN was created and appointed in what appeared to be a hurried process, when the Minister sacked the entire Medical Board for alleged incompetence. The apparent incompetence was a justifiable claim, when complaints took years to be processed and applications for registration sneaked IMGs into places where they just did not belong. But to create an entire new bureaucracy takes time, and it was obvious that the Minister had been planning this for a long time. There was no hurried process. There was a deliberate plan developed over a long time, probably starting before the present government was elected.

QUEENSLAND HEALTH CONTRACTS currently being offered are wholly unilateral and unacceptable. But here's the reality of life. The AMA can moan and bleat all they like, the SMOs can protest all they like, but at the end of the day the contracted doctors will have to be bullied into accepting unacceptable contracts or try their luck in the big bad world of private medicine. And there just isn't a big enough private market in Queensland to suddenly employ that many doctors. The AMA/AMAQ does not condemn contracts (as contrasted with the main alternative of enterprise bargaining), we just do not approve of THESE contracts, offered by a bullying unopposed government with no real options of genuine negotiation.

THE MEDICAL BOARD OF QUEENSLAND has been reconstituted. Half of the members are doctors, but doctors hand-picked by the Minister. It was not long ago that Ministers recognized a convention of inviting the AMAQ to nominate candidates, who then comprised half of the doctors on the Board. In this new Board, the AMAQ was not consulted. With all due respect to the six doctors appointed, all doctors in Queensland will regard them with an undying suspicion because of the manner of their appointment. Worse, the Chair of the new Board is a nurse. Sure, there is some professional jealousy here, because doctors will never accept being governed by a nurse. But even looking past that pettiness, the choice of a nurse to Chair the Board is unacceptable. No nurse can ever fully grasp the mentality and the philosophy of medical practice. We could have accepted a senior judge. **/cont:**

Cont:

Judges at least have the acknowledged track record of analytical impartial thinking (no matter how much of an ass the law is). But no doctor believes that a nurse fully appreciates how a doctor thinks and works. There is a presumption that nurses are indeed often in competition with doctors. And now we have the bizarre position that the Chair of the Queensland Medical Board cannot represent her state on the Medical Board of Australia, whose constitution requires that members must be medical practitioners. But no matter how unacceptable the composition of the new Board might be, it was created by an autocratic process of an unopposed government. Take it or leave it.

CONTRACTS: It is timely to review our thinking on the new contracts being offered to doctors.

1. Firstly, we have to acknowledge that the old way of doing business had its faults. The government was accountable to the taxpayer for the (low) level of inappropriate money going to doctors. There were individuals who, to be blunt, defrauded the taxpayer, and more who took advantage of opportunities for easy pickings. And there were significant systemic shortcomings. But there were other ways of overcoming those shortcomings.
2. No matter how you look at it, the government's priority is budget savings. They have to produce the same product at a lower cost.
3. There is an underlying agenda of faceless bureaucrats exercising control over the uncontrollable herd of cats that doctors always are.
4. Being individual contracts, the new order of business offers infinite potential for a divide-and-conquer approach.
5. New contracts to old employees can turn them into new appointees, with loss of accrued benefits and seniority.
6. The new contracts do not appear to cure the major systemic failures of the old system, viz lack of clinical oversight and lack of corporate governance.
7. Doctors who refuse to sign the impossible contracts will not be sacked wholesale but will transition over to a MOCA agreement that might well be even less palatable than the contracts. Even the government knows it has to deliver services, and the Yes Minister hospital without patients might save money but won't win votes.
8. Governments in other states, where they do have Senates and don't enjoy massive electoral margins, will be watching closely the outcome of the Queensland experiment. For the sake of our interstate colleagues, we cannot troop like lambs to the slaughter without the strongest possible dissent.

The AMAQ's proper role is not to endorse or condemn these contracts (although we DO condemn what is being offered), but our best role in this uneven playing field is to ensure that all our members have prompt access to timely information and access to the best legal and professional advice that any organization is able to give. And having reluctantly swallowed the bitter pill that most contracts will probably be signed, because our members do have mortgages and school fees to pay, our subsequent role is to continue to support our members whether they choose to accept or reject the unpalatable offerings.

Although I try to ensure that the information is accurate, and the conclusion consistent with AMA policy, the opinions expressed herein remain those of your correspondent

Wayne HERDY

North Coast Branch Councillor, AMAQ.

FEBRUARY 2014 UPDATE

Dr Sandra Peters - GPLO
Sunshine Coast Hospital & Health Service

Danielle Causer GP Liaison - Clinical Support,
Focus Health Network.

This month, we are "mixing it up a little" and providing a joint edition on behalf of the HHS GPLO role.

t has been an interesting few months since I stepped into the SCHHS GP liaison role awaiting formal appointment. Thanks to Danielle Causer at FHN who has held the fort and brought me up to speed. I want to acknowledge the work done by SCLMA and SCML in liaison with SCHHS and hope that we can continue to work together. As usual a large body of work is being done behind the scenes with little to see in the public arena.

Focus Health Network showcased a "Fresh Focus in Health", December 2013. Over 60 health professionals attended to hear speakers from across the Sunshine Coast, interstate as well as a special guest speaker from the UK. A highlight was to see the three of the Sunshine Coast's health industry most senior executive highlight how they are contributing to improved health outcomes for the Sunshine Coast community. Having Scott Lisle (Executive Director for Planning and Capacity Development (SCUH)), Terence Seymour (General Manager of the Sunshine Coast Private Hospital at Buderim) and the newly appointed Chief Executive Officer of the Sunshine Coast University Private Hospital, Oliver Steele all together and openly engaging in the question and answer session; highlighted the ability for collaboration of care here on the coast.

What's new on FHN website www.fhn.org.au :

- Nambour General Starters and Leaver's list
- CVC Social Assistance information

The public dermatology service has started at Nambour General Hospital. They will be running 3 clinics every week and 4 on alternate weeks. There is currently no waiting time as this is a new service. Referrals are accepted for adult patients only and should be addressed to DR LEITH BANNEY via the usual channels.

The hospital software programme has undergone a coding change to allow for the referrals reminder to be generated 60 days ahead of the next review appointment at SOPD (rather than 12 months ahead). This was requested by GPs to ensure a more meaningful clinical review of the patients' condition. It could also present an opportunity to assess whether the patient needs to attend the hospital for review. All too often the initial management question has long been answered and the patient receives all ongoing management in primary care.

You will all have seen the information about the Musculoskeletal Service or Non-Operative Pathway which is a pilot intervention beginning next month through the Orthopaedic Department. Currently 85% of patients seen at orthopaedic SOPD return to the GP for management as they do not convert to surgical wait list. The pilot will run for 6 months and will be evaluated for continuation at its conclusion.

Most of the work which we are involved in as GPLOs is to improve communication between GPs and hospital at times of transfer of patient care. Work continues on transfer of care documents back to primary care specifically from Emergency Departments. There are a number of barriers which the consultants have identified.

We are currently performing an audit of referrals into SOPD from primary care which will help to inform the movement of locally developed evidence based clinical pathways for referral and patient management. Next month we will be participating in education sessions around discharge documentation with the new interns. If you could share de-identified summaries which are suitable for teaching purposes I would be very grateful.

There is more – but if anyone is still with us, we will spare them until next month!

Cheers,

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Letter to the Editor

Following the decision by the Area Health Service that, in the Financial Year 2013-14, financial support for Cardiac Rehabilitation Programmes in the Sunshine Coast Area would be significantly curtailed, the Nu-Life Service provided by my team through the Noosa Hospital at Noosaville will cease to accept hospital referrals for Public Patients effective from 01 February 2014.

Since support ceased we have continued to provide rehabilitation services, however this is no longer financially viable and the four hundred or so public patients who have received a service over the years will need, in the future, to seek it elsewhere.

I understand that Dr Peter Larsen has the responsibility for the reorganisation of rehabilitation services to whom enquiries could be directed or alternately to Kevin Hegarty.

I would at this time like to express my appreciation to the local medical association members for their support since my relocation to Noosa in 2000.

Yours sincerely,

Dr Tony Neaverson

Editor's Comment: We have been advised that the appropriate point of contact for this issue is the acting Director of Cardiology, Dr Mark Johnson, Sunshine Coast Hospital and Health Service on 5370 3727.

Your Membership Survey

Results to date .....

51 responses received. Thank you!

Suggestions - Topics, Monthly Clinical Meetings:

- Allergies & sensitivities, esp re gluten and diet
- Happy to do a talk on Child Protection / Mandatory Reporting (30-40 minutes) if anyone was interested.
- Benign prostatomegaly – best treatment & place of surgery
- Childhood obesity; aboriginal health
- Impotence. Male & Female. Causes, treatment.
- Drug addiction – Wayne Herdy or ATODS staff
- Members who have spoken at Conferences.
- Time Management, Clinical Leadership, Role of social media, Transition from paediatric to adult care from the adult physician/GP perspective.
- More hands on lectures – surgery, oncology, radiology, paediatrics
- Speakers to start on time – talk for only 20 mins.
- Regular updates on the status of the SCUPH and the new public hospital build and tenders
- Good variety now – local presenters preferred
- Occasional Community / (non) medical topics. Ask Jimmy Dick to talk about 'Mercy Ships'
- Short presentation by a Sunshine Coast MLA – different one each meeting
- Medical Practice updates; Medical service in developing countries
- Would like some ophthalmology
- I would be happy to present a talk on "Screening versus diagnostic breast imaging"
- Enjoy the content & promptness of both starting and finishing
- Q & A – ask a question & get various specialist to give answers
- Suggest asking Fiona Simpson to attend meeting
- Medico / Legal issues
- Privacy of Medical Records emails, clinical photos
- Dermatology
- More informative AMA & AMAQ matters
- Already excellent topics and speakers. Thanks!

Suggestions - Meeting Venues:

- Brightwater Hotel - 22 / 51 votes
- Ebb - 41 / 51 votes
- Mdore Surf Club - 32 / 51 votes
- Yacht Club - 25 / 51 votes

(reminder that sponsors often choose venue based on their financial capacity)

Suggestions - Newsletter:

- Articles - Allergies & sensitivities
- Subject matter relevant & broad-based
- More case studies
- Seek some "Guest Contributions"
- Happy with content (many comments)

Comments - Website:

- Haven't viewed for some time
- Would like private area for members with contact details available
- I didn't know we had one
- It would be helpful to have a printable PDF form for applications & Directory. ***(already there!)***
- Great site (many comments)
- I have never looked at it until today – Good – plenty of information.

Thank you to all who have responded - your Committee will discuss all responses at future Committee meetings.

MEDICAL MOTORING

with Doctor Clive Fraser

FIAT 500

"l'arte di arrangiarsi"

It's been 60 years since Alberto Sordi starred in the 1954 Italian comedy "l'arte di arrangiarsi".

He was cast as a twenty year old layabout who loves only two things, women and money, not in that order.

Like most Italians of the day he was having an affair with his Uncle's wife and then moves on to marry a woman who is ugly, but rich.

In keeping with the politics of the day he goes from being a fascist, to a communist and then a Christian democrat only to end up pretending to be from Frankfurt selling fake German goods on the streets of Rome.

If you haven't figured it out by now the title of the movie "l'arte di arrangiarsi" roughly translates into an Italian saying of the time "the art of getting by".

So it was with the plot of this movie on my mind that I set off in a 2014 Fiat 500.

Would I find a mistress, would I marry into money, would I change political allegiances, or would I somehow just 'get by'?

If there was an award for the cutest looking car ever it would have to go to the Fiat 500 (both models).

Originally produced from 1957 to 1975 there were four million happy Fiat 500 owners who probably still regard it as the best little car they ever owned.

In its original incarnation there was an air-cooled 497cc motor producing 13 bhp (9.7 kW) and no back seat.

Fiat 500's were assembled all over the World, but the New Zealand built cars were lovingly called 'Bambinas' which will forever be the name that I know them by.

I have very fond memories as a medical student of trips in a colleague's stretched Fiat 600 from the Italian suburb of St Lucia to Indooroopilly Shoppingtown.

There was room for all five from my Anatomy table in the little car.

It was slightly more powerful than the Fiat 500 with 28 bhp and was water-cooled.

This was a particularly important feature as it over-heated constantly in the harsh Queensland tropics and it was un-wise to travel anywhere without plenty of water to top up the radiator.

On a fateful trip from Brisbane to Bundaberg at mid-night the Fiat 600 over-heated every 25 miles, but amazingly it just kept going.

Could that happen in a modern car?

I think not!

And there was no risk of picking up a speeding ticket on the highway in the Fiat because 59mph was as fast as it could go.

To celebrate the 50th anniversary of the Fiat 500 an all-new model was released in 2007 based on the Ford Ka.

That's basically the same vehicle on sale in 2014 and frankly I'd be disappointed if they ever changed anything about the car from now on.

For $14,000 drive-away you can have yourself a brand-new Fiat 500 Pop.

Power is from a water-cooled 1.2 litre engine pumping out 51 kW or for those petrol-heads out there they might like the 500S model with 74 kW.

MEDICAL NOTORING /cont:

Automatic transmission adds $1500 to the price of a Fiat 500.

Just like the original Fiat 500 there still is no glove box. This storage would not have been missed by Gina Lollobrigida who never wore gloves, or much at all.

Whilst I'm on the subject of Gina Lollobrigida, I am hoping that someone can enlighten me on why despite Italians having a reputation as great lovers, their country has such a low birth rate, particularly whilst the Vatican continues to have very conservative policies about birth control?

Though there are a number of variants of the Fiat 500 with prices going all the way up to $75,865 for an Abarth 500 695 Ferrari, I think that for $14,000 the Fiat 500 Pop is half the price of a Mini or VW Beetle and at that price it's a steal.

2014 Fiat 500 Pop vs (1957 Fiat 500)

For: The cutest car(s) in history.
Against: What could you ever replace it with?

This car would suit: Nostalgic Italian doctors in no hurry.

Specifications:

1.2 litre 4 cylinder (0.5 litre 2 cylinder) petrol
51 kW power @ 5,500 rpm (9.7 kW)
102 Nm torque @ 3,000 rpm
5 speed (4 speed) manual
Length 3.5 metres (2.97 metres)
5.1 l/100 km (4.5 l/100 km) combined
$14,000 Drive-away (465,000 lire)

Fast facts:

Fiat and Chrysler merged in 2013.

The 2014 Fiat 500 is made in Poland (and Mexico).

Safe motoring,

Doctor Clive Fraser

Email: doctorclivefraser@hotmail.com

ENT SPECIALISTS GP EDUCATION DAY

Presenters

Dr David McIntosh Paediatric ENT Specialist

Dr Daniel Timperley Rhinology and reconstructive nasal surgery specialist

Dr Theo Athanasiadis Laryngology and sleep apnoea specialist

Dr Sharad Chawla Specialist Otologist

Please join us for a day of education on modern ENT management

Date: Saturday 29 March 2014

Time: 9am-5pm, breaking for lunch which will be provided as part of the meeting

Venue: Mantra Hotel, Mooloolaba, Sunshine Coast

Cost: FREE for all RSVPs received by March 14, $110 there after

Topics to be covered include:

- Current indications for antibiotic treatment for acute otitis media
- Modern management of sinusitis
- Restorative procedures for vocal dysfunction
- Current indications for cochlear implants and bone anchored hearing aids
- Simple management of common ENT emergencies
- Sleep disordered breathing in children
- Role of the ENT surgeon in assessing sleep apnoea
- Surgery for adult sleep apnoea
- ENT perspective on chronic cough
- Reflux disease and its ENT impact
- Management of early laryngeal cancer
- Assessment of the dizzy patient
- Modern management of Meniere's disease
- Indigenous ENT problems

There will also be a general question and answer session where you can ask about any ENT topic of interest to engage in a group discussion.

To RSVP your attendance, please email us your name and best contact number to the following:

entevents@outlook.com

Welcome - James Askew (General Surgeon)
New SCLMA member - November 2013.

Dr James Askew has commenced practice at the Sunshine Coast University Private Hospital. He is a Queensland trained General Surgeon with a sub-specialist interest in Upper GI and bariatric surgery. Dr Askew offers a broad range of general surgical procedures and has an interest in:

- *Laparoscopic gallbladder & hernia surgery*
- *Skin cancer surgery*
- *Upper GI surgery – for obesity, reflux disease, hiatus hernias, and cancers.*
- *Acute Surgery*

Dr Askew was educated in Brisbane, graduated from UQ and spent many Registrar years throughout SE Queensland. He particularly enjoys the Sunshine Coast for its relaxed lifestyle, amazing weather, great seafood and friendly communities. He has moved here with his young family and plans to learn to surf and re-learn playing tennis. Dr Askew is supportive of the role AMAQ takes in representing Doctors and joined the SCLMA in order to keep abreast of current issues and to socialize across medical disciplines!

Pending Members - February 2014 Record number of Applications received:

- ***Dr James Tunggal***
- ***Dr David Wright***
- ***Dr Kim Latendresse***
- ***Dr Hans Lombard***
- ***Dr Geoff Byrne***
- ***Dr Mara Clarsen***
- ***Dr Priscilla Martin***
- ***Dr Stuart Collins***
- ***Dr Vanessa Nuske***
- ***Dr John Evans***

TAYLORS WINES

Three generations of Taylors ensure that the wines produced from their magnificent Clare Valley vineyards are of the highest standard. Bill Taylor and his two sons, Bill and John, were firmly entrenched into the wine industry as wine merchants. The passion to create their own world class Cabernets was realized with the purchase of 178 hectares of Terra Rossa soil on the Wakefield River in the Clare Valley in 1969.

The first commercial vintage was in 1973 with the Cabernet Sauvignon winning a gold medal in every Capital city wine show in its year of release in 1975. The Taylors' name became synonymous with quality, and expansion in 1983 saw them purchase another 113 hectares. Expansion has been rapid with the addition of 32 hectares in 1989, 161 hectares in 1994 and most significantly the 250 odd hectares of the St Andrews vineyard.

Innovation always lays a fertile path for the future. In 2000, all the Riesling produced was sealed under Stelvin screw cap and in 2004 all wines were sealed this way. In 2009 Taylors produced the first 100% Carbon Neutral wine under its Eighty Acres label.

Seven labels exist with each displaying different philosophies of production. The "Promised Land" range is meant to be fruit dominated and ready to drink. "80 Acres" is named after the original farmed block and is 100% carbon neutral. It has lively fruit with some elegant structure. The "Taylors Estate" range gets more serious expressions of terroir and quality fruit.

The" Jarraman" range purposely blends the best fruit of two regions. This gives a chance for the single varietal fruit characteristics to shine. The flagship wines only made in certain vintages is the "St Andrews" range. These are the most elegant structured wines that give plenty of value per dollar. The "Visionary" is named after Bill Taylor and is extremely rare being Cabernet in exceptional years.

The most fascinating range includes the "TWP- Taylors Wine-making Project" wines. This range finds the tinkering and testing of small parcels of less common varieties. Current release includes a Grenache, Shiraz Mataro and a Cabernet Sauvignon, Merlot, Malbec and Cabernet Franc.

The Taylors belong to the AFFW- Australia's first families of wine. Twelve other families are members and believe in the expression of terroir, quality and commitment to the wine industry.

Exports have been successful with the notable change in name to "Wakefield Wines" as the name Taylors is linked the Portuguese wine company.

Wines Tasted

- TAYLORS ESTATE CLARE VALLEY RIESLING 2013- Colour- light yellow. Nose- sweet honey suckle and lime florals. Palate- medium weight anterior palate with a moderate acid backbone. This is a great value example of Clare Valley Riesling and was enjoyed with some Fresh Mooloolaba Prawns and lime aioli. Cellar 3-5 y.

- TAYLORS ST ANDREWS CLARE VALLEY CHARDONNAY 2012- Colour pale yellow, tinge of green. Nose- complex white peach, funky lees and yeast aromas. Palate- lush and broad in the anterior palate with nice acidity. Made in the new mould with hints of Malolactic fermentation but restrained fruit and oak balanced beautifully. Enjoyed with King Island Triple Bree. Cellar 5-7 years.

- TAYLORS WMP GSM CLARE VALLEY GRENACHE SHIRAZ MATARO 2010- C- deep garnet, N- red currants, rich candied fruits , tobacco leaf and herbal notes. P- Generous fruit on the anterior palate with a mild tannin structure. Overall a luscious wine that opened up over 2 hours. Enjoyed with some prosciutto and Jamon Ham. Cellar 6-7 years.

- TAYLORS ST ANDREWS CLARE VALLEY CABERNET SAUVIGNON 2009- C-Deep red brown brick. N- Rich deep cassis and mocha notes with a background of herbs. P- Full velvety flow of rich fruit flavours. There is very little mid palate collapse and the balanced tannins ensure lip smacking satisfaction. The best value high end Cabernet that I know of. Enjoy with my old favorite –grilled "anything bleeding" Cellar for 8-10 years.

Dr Plonk .....

ARE YOU GETTING THE RIGHT ADVICE?

Poole Group
ACCOUNTANTS & INVESTMENT ADVISERS

I was recently referred a medical client who had existing insurance policies set up through another adviser within their Self Managed Superannuation Fund (SMSF). The other adviser had recommended the client own all of their policies through the SMSF including a Business Expense Policy (BEX). Apart from other issues relating to the Total & Permanent Disability (TPD) and Income Protection held through the SMSF, the greatest concern was the BEX policy.

BEX policies are designed to provide the life insured a monthly replacement of income to cover ongoing fixed costs of the business, e.g. rent, equipment leasing, business loans, staff costs etc, if the life insured is unable to work due to a disability.

The issues of holding this type of policy through a SMSF are;

- The policy does not meet the "Sole Purpose" act of the superannuation fund.
- The policy does not meet any "Core" or "Ancillary" benefits under the superannuation rules.

Essentially this makes the policy a non-compliant contract through the super fund and has the following ramifications;

- In the event of a claim the benefits **cannot** be released from the super fund as they do not meet a condition of release under the Superannuation Act. This would obviously have great financial impacts on the client at time of claim as the client would not be able to access the monthly benefit to pay ongoing fixed business expenses for their medical practice. Hence the client could be forced to close the doors of the business and still have ongoing fixed costs that would have to be self-funded.

- The premiums are not tax deductible through the super fund as it is a non-compliant contract. Again there is no advantage for the client to hold the policy through the SMSF as business expense policies are tax deductible when they are owned and paid for outside of the super fund.

This simple case of policy ownership has the immediate impact on the SMSF not being in line with the super fund regulations and not being compliant. The greater concern is not being able to access funds at time of claim and the follow on financial impact of this restriction.

As you can see it pays to get the right advice and ensure you are consulting a specialist when it comes to insurance requirements.

For a free review of your insurance needs, contact Hayden White who is Poole Group's in-house risk specialist.

Ph: 07 5437 9900 Email hwhite@poolegroup.com.au

POINTS TO PONDER …….. WAYNE HERDY

AN ALCOHOL SUMMIT?

Alcohol and its impact on society and medical practice have been getting increased publicity lately. And as far as I can tell, this is not the customary seasonal spotlight that shines on alcohol and driving over the Christmas season. The NSW government has taken an initiative over the past six months or so to curb alcohol-related violence. The Queensland Opposition (Courier-Mail 21st Jan) has followed up with a call for similar measures to apply in Queensland. And now the AMA, prompted by calls from its emergency physician members, has raised a demand for another alcohol summit. Overseas, Canada has publicly raised the debate for a zero-alcohol tolerance in drivers, citing evidence that there is no safe level for drink driving.

Doctors might be fond of our reds, and cardiologists love the protective effects of small doses of alcohol, but we also recognize only too clearly the medical sequelae of excess drinking. We have determined that "safe" drinking is two standard drinks per day for men and something less than that for women. That is for the medical consequences of alcohol such as liver disease. But the real dangers of alcohol lie in excess drinking, which is culturally ingrained into Australian society. We see short term physical problems such as violence and accidents (not only motor vehicle accidents). We see long-term issues such as social dysfunction, unemployment and homelessness.

The time might be right for another national conversation. That might take the form of a summit, but please don't let it turn into a gabfest without outcomes. It might produce legislation that curbs individual freedoms, and that will spark a civil-libertarian debate in itself. Ultimately we are looking at a need for cultural change, a generational and seismic change that won't occur in my lifetime. We will have once again the debate about how much the government should intrude into peoples' lives. But there should be no debate about the fact that the medical profession should be taking a lead in advising the community about a near and present social disaster.

PHARMACY FLU VACCINES.

The conflict between pharmacies and GPs about who is going to give flu vaccines has reared its annual head.

(i) There is considerable truth to pharmacists' assertions that GP's do not have enough available appointments to meet the brief seasonal demand for flu vaccination. We GP's have to re-examine our appointment schedules, at least for the month or so of the vaccination season.

(ii) Doctors claim that only medical centres should administer vaccines, for reasons of safety. In fact, significant influenza vaccine reactions are rare, so we must admit this argument has only relative value. The chance of a material adverse event requiring medical intervention is tiny. That disquiet does not apply to vaccinations other than the relatively innocuous flu vaccine. Other vaccines are not as forgiving.

(iii) I am troubled by the possibility that, if doctors allow pharmacies to administer flu vaccines because of their good safety record, that will open the door for pharmacies to seek to administer a much wider range of not-so-innocuous vaccines.

(iv) Doctors are always troubled by fragmented care and fragmented records. Vaccines administered outside our own clinics are rarely recorded on our own records. But then we encounter the same problem with employer-sponsored vaccination programmes (including most hospitals). The PCEHR will partly solve this dilemma – but only if every health provider contributes to the record.

(v) We are unhappy that the person administering the vaccines may not be as well qualified as the vaccine nurses in our own practices. Before we argue this too strongly, we need to examine our own houses. Are our practice nurses as well qualified and experienced as we claim? In most cases, because we are administering childhood vaccines year-round, this is a pretty safe assertion.

(vi) Deep down, my own strongest personal objection is the issue that the person prescribing the vaccine is effectively the same person as is obtaining a financial benefit from dispensing the vaccine. The potential financial conflict is, in reality, the real reason why most pharmacies do want to run their own vaccination clinics.

POINTS TO PONDER ..... Wayne Herdy / cont:

(vii) And an extension of that concern is the progressive encroachment of pharmacies into areas of practice traditionally the domain of the family GP. I shudder at the advice from some of their diabetes "specialists" and their ultrasonographic diagnoses of osteoporosis borders on criminal negligence.

At the end of the day, permitting pharmacy vaccination clinics is likely to increase the overall rate of immunization and increase herd immunity, so there is good reason for doctors to enter into meaningful dialogue with pharmacy about a mutually agreeable compromise. This is the decade of team care, and pharmacists are legitimate aspirants to be part of the team, a role that they have been unenthusiastic about embracing. But I still do not see a genuine need for pharmacies to embark on what is for them a risky strategy when most of them operate within direct sight of the nearest GP.

GP CO-PAYMENTS.

Is this a real debate, or was it a political strategy to keep boats off the front pages? If the latter, it didn't really succeed, did it?

If it is a real debate, what is it really all about?

On the one hand, the government's pot of gold for health is limited, so the medical profession must be prepared to examine any alternative ways of getting more dollars into the system. Co-payments, whether paid directly by the patient or indirectly by the patient through their insurance premiums, are a way of attracting more non-government dollars into our own pockets (yes, I know, "government dollars" is the same as taxpayer dollars and more or less the same as patients' dollars, but we're looking at varying pathways, not varying the ultimate source of the cash).

We all like the idea of sending a price signal to our patients to make them think twice about whether the consultation is really necessary. It won't make any difference to our end-of-year vacation funding, but it will make a difference to our appointment schedules. Or will it? In the brief experiment with co-payments in the 1980's, the trend was starting to show that the price signal was not going to reduce the number of consultations.

What a price signal will do is to create a barrier for the genuinely disadvantaged. Non-bulk-billing practices will confirm that our average pensioner actually takes some pride in the fact that they are contributing to the cost of seeing their doctor, an experience that was also voiced during the 1980's experiment. But of the 80% of patients who are currently bulk-billed, none of us needs to look too far to find at least a few, and probably a majority, for whom $6 would become an impenetrable barrier. And we fear that it would be mostly the children that we would see less frequently. GPs would retain the discretion about individual billing, but we cannot run a charity service indefinitely.

A complication is whether the Medibank Private agreement with IPN comprises a co-payment. I'll argue all day that it does. I at least wouldn't like to be defending the GP who wants me to argue otherwise in the High Court. The complication isn't so much over the question of whether private insurers should be paying a co-payment on behalf of their clients. The complication is that, historically, insurers have never resisted the temptation of intervening in patient care. Insurer involvement is inevitably a fast-track to managed care and economic rationing. Insurers should only be allowed into this game if the rules forbid them from ever becoming involved in clinical decision-making.

And the cost of GP consultations represents a small percentage of the national health bill. GPs are the reason why Australia enjoys the second-highest life expectancy in the world. The high end of health costs is in hospitals, and in high-tech medicine which adds regrettably little to the average life expectancy of the population.

Are we barking up the wrong tree altogether?

Wayne Herdy

REDCLIFFE LOCAL MEDICAL ASSOCIATION NEWSLETTER

Redcliffe LMA produces a similar newsletter

For full details re advertising go to their website:

www.rdma.org.au or email: RDMAnews@gmail.com

ADVERTISING GUIDELINES:

To comply with Section 133 of the National Law and guidelines, advertising of services must not:

Paragraph (a) “Create or be likely to create unwarranted and unrealistic expectations about the effectiveness of the health services advertised”

Paragraph (f) “Claim that the services provided by a particular regulated health profession are better, as safe as or safer than others”

Paragraph (o) “Contain any claim, statement or implication that a practitioner provides superior services to those provided by other registered health practitioners”

SUNSHINE COAST LOCAL MEDICAL ASSOCIATION Inc. ABN: 56 932 130 084

MEMBERSHIP APPLICATION

Enquiries: Jo Bourke Ph: 5479 3979 Mb: 0407 037 112 Email: jobo@squirrel.com.au

NAME	**Surname:**	**First Name:**
	EMAIL:	
PRACTICE ADDRESS: This is for delivery of your monthly invitation and monthly newsletter by Couriers from Sullivan Nicolaides Pathology thus avoiding postage costs to the SCLMA.		
	Practice/Building	
	Street:	
	Suburb:	Postcode:
	Phone:	Fax:
ALTERNATE ADDRESS: (if practice address not applicable)		
	Street:	
	Suburb:	Postcode:
	Phone:	
PRACTITIONER DETAILS:		
	Qualifications:	
	Date of Birth:	Year of Graduation:
	Hospital employed / Private Practice (cross out one)	
	General Practice / Specialist (cross out one)	
	Area of Speciality:	
PLEASE NOTE:	***Retired doctors who wish to join the Association are required to attach a letter of good standing from their respective College.***	
PROPOSERS: (to comply with the Queensland Associations Incorporation Act, two financial members of the Association are required to nominate each applicant for ***new*** membership. Members ***renewing*** their membership do not need proposers).		
1. NAME:	**Signature:**	
2. NAME:	**Signature:**	

ANNUAL SUBSCRIPTION (GST included):	**(Please tick)**	**DELIVERY OPTIONS**
Full-time ordinary members - GP and Specialist	$ 55.00	**Your Monthly Invitation**
Doctor spouse of full-time ordinary member	$ 22.00	By Email?
Absentee or non-resident doctors	$ 22.00	By Courier?
Part-time ordinary members (less than 10 hours per week)	$ 22.00	By Post?
Non-practising ordinary members, under 60 years old	$ 22.00	**Your Monthly Newsletter**
Residents & Doctors in Training	Free	By Email?
Non-practising ordinary members, over 60 years old	Free	By Courier?
Patron and honorary members	Free	By Post?

Payment can be made by cheque payable to SCLMA or by direct debit to the

SCLMA Westpac Account. **BSB: 034-243 ACCOUNT NUMBER: 11-9298**

A TAX RECEIPT WILL BE SENT FOR YOUR RECORDS.

Please return this form with your cheque OR details of your E.F.T. to:

SCLMA PO BOX 549 COTTON TREE 4558

Please note*: Membership applications will be considered at the next Management Committee meeting.*

The Sunshine Coast Local Medical Association has Public Liability Insurance

TAKE 5 .....

CRICKET QUIPS (sent in by M.D.)

Q. What do you get if you cross the English cricket team with an OXO cube?
A. A laughing stock.

Q What's the height of optimism?
A: English batsman putting on sunscreen.

Q. What's the difference between an English batsman and a Formula 1 car?
A. Nothing! If you blink you'll miss them both.

Q. What do English batsmen and drug addicts have in common?
A. Both spend most of their time wondering where their next score will come from.

Q. What does an English batsman who is playing in The Ashes have in common with Michael Jackson?
A.They both wore gloves for no apparent reason.

Q. What is the difference between Cinderella and the Pommies?
A. Cinderella knew when to leave the ball.

Q. What's the difference between the Pommies and a funeral director?
A. A funeral director isn't going to lose the ashes.

LUNCH PLANS:

A group of chaps, all aged 40, discussed where they should meet for lunch. Finally, it was agreed that they would meet at Wetherspoons in Birmingham because the waitresses were fit & wore mini skirts.

Ten years later, at age 50, the friends once again discussed where they should meet for lunch. Finally it was agreed that they would meet at Wetherspoons in Birmingham because the food and service was good and the beer was excellent.

Ten years later, at age 60, the friends again discussed where they should meet for lunch. Finally it was agreed that they would meet at Wetherspoons in Birmingham because they could dine in peace and quiet and it was good value for money.

Ten years later, at age 70, the friends discussed where they should meet for lunch. Finally it was agreed that they would meet at Wetherspoons in Birmingham because the restaurant was wheelchair accessible and had a lift for the disabled.

Ten years later, at age 80, the friends discussed where they should meet for lunch. Finally it was agreed that they would meet at Wetherspoons in Birmingham because they had never been there before.

LAWYERS ON A JURY:

A trial had been scheduled in a small town, but the court clerk had forgotten to call in a jury panel. Rather than adjourning what he thought was an exceptionally simple case, the judge ordered his bailiff to go through the courthouse and round up enough people to form a jury. The bailiff returned with a group of lawyers.

The prosecutor felt that it would be an interesting experiment to try a case before a jury of lawyers, and the defense counsel had no objection, so a jury was impaneled. And the trial went very quickly -- after only an hour of testimony, and very short closing arguments, both sides rested. The jury was then instructed by the judge, and was sent back to the jury room to deliberate.

After nearly six hours, the trial court was concerned that the jury had not returned with a verdict. The case had in fact turned out to be every bit as simple as he had expected, and it seemed to him that they should have been back in minutes. He sent the bailiff to the jury room, to see if they needed anything.

The bailiff returned, and the judge asked, "Are they close to reaching a verdict?" The bailiff shook his head, and replied, "You're honor, they're still doing nomination speeches for the position of foreman."

DEFINITION:

No dictionary has ever been able to define the difference between "complete" and "finished." However, in a linguistic conference, held in London England, and attended by some of the best linguistics in the world, Samsundar Balgobin, a Guyanese was the clever winner.

His final challenge was this. Some say there is no difference between "complete" and "finished." Please explain the difference in a way that is easy to understand. His response was:

When you marry the right woman, you are "complete." If you marry the wrong woman, you are "finished." And, when the right one catches you with the wrong one, you are "completely finished."

His answer received a five minute standing ovation.

CHRISTMAS IN JULY 2014 - SATURDAY 19 JULY 2014

PELICAN WATERS
GOLF RESORT & SPA • CALOUNDRA

We've checked it out - beautiful venue!

ALL Accommodation above function room

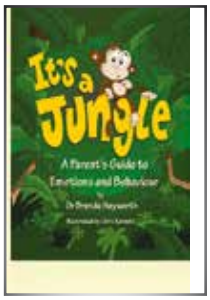
Plans afoot for a golf day on Sunday

Plans afoot for Aveda Spa to open on Sunday.

MARK YOUR DIARIES NOW!

CLASSIFIEDS

If you are LOOKING FOR A BOOK about CHILDREN'S BEHAVIOUR that:



- is easy for parents to read
- helps children develop better self-control
- has practical strategies
- helps parents feel better about themselves
- creates an opening for DOCTORS to talk with PARENTS about their own emotional health

"It's a Jungle: A Parent's Guide to Emotions and Behaviour" is written by local Child and Family Psychiatrist, Dr Brenda Heyworth, and is available for $29.95 plus P&H from the website **www.itsajungle.com**

February 2014

DR KARL SCHULZE - CHANGE OF ADDRESS

- Sunshine Vascular Imaging has moved from Caloundra Private Hospital to 13 Fourth Ave, Caloundra (Dr Alana Harris' rooms).
- Sunshine Vascular Imaging performs all venous and arterial ultrasounds using the latest ultrasound technology and specialist vascular sonographers. All ultrasounds are bulk billed. **Ph: 07 5453 4300**

Website: www.sunshinevascular.com.au

February 2014

DR GLENN SPROLES, VASCULAR SURGEON CHANGE OF ADDRESS FROM FEBRUARY 2014

- Consulting rooms at Medisuites, QDI, 5 Innovation Parkway Birtinya have relocated to Lake Kawana Specialist Centre, Ground Floor, 5 Innovation Parkway, Birtinya Qld 4575

All appointments: Ph: 07 3832 4636

February 2014

DR PETER PATRIKIOS CHANGE OF ADDRESS FROM FEBRUARY 2014

- Dr Peter Patrikios, Neurologist, has moved to 27 Second Ave, Maroochydore. (No longer at Birtinya). He is on Medical Objects.

Ph 5479 2110 Fax 5479 2162.

February 2014

GP MAROOCHYDORE, SUNSHINE COAST

- Busy Family Practice is seeking a female PT/FT VR GP to work with us. Our Practice is modern and fully computerised with Medical Director and Pracsoft software, nursing support and a very harmonious and great administrative and GP team to work with.
- Please contact Practice Manager:

pm.wrmc@yahoo.com.au or 0409447096

February 2014

SUNSHINE COAST QLD – GP POSITION

- Very busy, highly respected teaching practice, mixed billing, owned by principals, to replace colleague leaving to pursue other interests. Wide range of services. RA2. No after hours. Live by the sea or hinterland.

Please send CVs and expressions of interest to :

practicemanager@nambourmedical.com.au

November 2013

AVAILABLE FOR LEASE –

New stand alone professional offices, approx**imately 180m2, Caloundra. Contact Robyn** Ph: 0458 934 924

November 2013

GENERAL PRACTITIONER OPPORTUNITY NOOSAVILLE SEVEN DAY MEDICAL CENTRE

- Busy, well-established and highly reputable mixed-billing general practice currently seeking a GP (preferably VR) to join their friendly and professional team of Doctors and support staff ideally on a full-time basis. Part-time will also be considered.
- Located within a busy shopping centre with onsite pathology and a pharmacy adjacent, the centre is fully computerised and accredited to 4th edition RACGP standards.
- Full access to administration and nursing support, including a dedicated Chronic Disease Management Nurse. Full clinical and billing autonomy, a full established patient base from commencement, as well as flexible session arrangements are available.

For expressions of interest or to discuss further please contact the Practice Manager Louise Faleono on **07 5473 4100** or email **louise.faleono@healthscope.com.au**

November 2013

INTRODUCING - DR CHELLAM KIRUBAKARAN - CONSULTANT PAEDIATRICIAN

- Dr Chellam is a senior clinician currently working at the Mildura Base Hospital as consultant paediatrician. From November Dr Chellam will be visiting Noosa on a regular basis to conduct paediatric outpatient clinics.
- Referral letters may be sent to: Dr Chellam Kirubakaran, Nu-Life Medical Centre Suite 205A First Floor 90 Goodchap St Noosavile.

Ph: 07 5474 2053 Fax: 07 5474 0876 Mobile: 0437 356 177
Email: chellamk@yahoo.co.uk

November 2013

Classifieds remain FREE for current SCLMA members.

$110 for non-members

Ph: 5479 3979. Mobile: 0407 037 112.

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Classifieds will remain on the list for three months unless notified.