NEWSLETTER
July 2015

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

We are experiencing a colder than expected winter, and the recent weather has required coats that rarely see the light of day in Qld. The images from the Granite belt, blanketed in its heaviest snow fall in 30 years, has us wondering if there has been some stealthy shift in the border of the Sunshine State. Perhaps NSW, licking their wounds after a State of Origin defeat, were trying to steal our home grown talent? What did make me chuckle though, was the way in which the media reported our recent cold snap. The frosty mornings that a generation ago might have elicited a comment or two about it being "a bit nippy", suddenly became an "Antarctic vortex". An extra 15 minutes in bed in the morning and a coat, hardly warrants this description which conjures apocalyptic images. Are we getting soft or is the media just desperate for an attention grabbing headline?

And on the subject of media, it has been revealed this month that the average attention span of a human has dropped from 12 seconds in 2000 to 8.25 seconds in 2015. It is estimated that a goldfish has an attention span of 9 seconds. It seems that with the explosion of social media and the internet, we can now be spoon fed information with very little effort on our part in regard to research and analysis of data to reach a conclusion. This information, along with some advice out of the USA (where else!), that doctors should drop the term hypertension, had me shaking my head in bewilderment. Apparently, some patients do not understand the word, and think it means they are stressed. Where amongst our leaders, are the champions of education and human achievement? Why are we, in the name of political correctness, watching so many paddle toward the shallow end of the pool where they can float along, never being challenged?

The rebate freeze is threatening to impact of the quality of care that general practice can provide. Many practices are preparing their patients for the fact that they will be paying more to see the doctor. Preventative care will become a casualty of the shrinking household budget. Even more challenging will be those consults that start with the phrase that all GPs fear, "I haven't been for a while doc, so I have a list". So, in the first 10-15 minutes, you deal with the rash, the mole they are worried about, the lump in their groin, their insomnia, the difficulties they are having caring for an elderly parent and repeat their prescriptions.

They then pull out the trump card, usually something along the lines of "I'm getting a little breathless and tight in the chest when I walk some days." Practical note for young GPs, get the list off of them at the start of the consult!! You glance at the computer and note you have four patients waiting, including a child with a fever.

What do you do? Push on, or ask the patient to make another appointment, hoping they don't have their myocardial infarct in the meantime? Medically, the answer is clearly to deal with the possibility of coronary artery disease at that time. However, the patient has booked a "standard" consult, cannot pay for a long consult and is unhappy to pay for a further appointment. The above scenario is not uncommon and will become more frequent as patients limit visits to their GPs because of cost. The third, and most expensive option for the health budget, would be to refer this patient to the local hospital service or even DEM. The SCHHS and QH are quite rightly trying to ensure appropriate referrals and have implemented "Referral Guidelines" and "Clinical Prioritisation Criteria". These require the GPs to have performed a series of investigations or trialled treatments prior to referral. A worthy endeavour, but only if general practice is adequately funded to perform these tasks.

Thursday 27 August is our AGM, and I encourage you to think about joining the committee. Bring your experience, a desire to support your colleagues and most importantly, a sense of humour. A nomination form is on page 29.

Kind Regards

Di Minuskin

The SCLMA thanks Sullivan Nicolaides Pathology for the distribution of the monthly newsletter.

Sullivan Nicolaides PATHOLOGY

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AUGUST 2015 NEWSLETTER

Deadline Date will be FRIDAY 14 AUGUST 2015

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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.

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Enquiries: Jo Ph: 5479 3979 or 0407 037 112
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Welcome to the July 2015 SCLMA newsletter.

Kevin Hegarty's column is back and it makes an interesting read in regards to costings for the new Sunshine Coast Public University Hospital. In regards to names I truly believe that the name should be changed to Sunshine Coast University Hospital. This name installs pride and excellence as opposed to the "Public" part of the current name. Ramsay on the other hand needs to drop the name "University" from its name. This creates a false perception as the current private hospital has absolutely nothing to do with a university and never will have. So let's clear up the nomenclature and set the record straight.

It was with delight that I read the tweet from the current state Minister of Health that all clinical services in particular, Radiology, Radiation Oncology and Pathology were staying public and were not going to be outsourced to the private sector. This makes the delivery of Cancer Care Services on the Sunshine Coast a far more cohesive proposition.

Staying with Pathology services, I recently received an email in regards to inappropriate pathology requests.

The Royal college of Pathologists of Australasia have released the following list of 10 inappropriate requests:

1. *Do not perform surveillance urine cultures or treat asymptomatic bacteruria in older patients unless there are urinary tract signs and symptoms*
2. *Do not perform population based screening for Vitamin D deficiency*
3. *Do not perform PSA testing for prostate cancer screening in men with no symptoms and whose life expectancy is less than 10 years*
4. *Do not perform routine pre-operative screening tests for low-risk surgery*
5. *Do not perform IgG4 allergy tests, total IgE in the investigation of allergy*
6. *Do not perform heavy metal tests for non-specific symptoms in the absence of exposure*
7. *Do not test for Lyme disease for non-specific symptoms in the absence of exposure*
8. *Do not perform serum tumour marker tests except for the monitoring of a cancer known to produce these markers*
9. *Do not routinely test and treat hyperlipidemia in those with a limited life expectancy*
10. *Do perform high sensitivity D-dimer assay in outpatients rather than imaging to exclude venous thrombo-embolism in patients with a low clinical probability*

Ok to end on a lighter note:

Fry off 2 diced onions with a packet of coarsely chopped bacon in a heavy based pan.

Place it into a slow cooker. Cube 3 large gravy beef steaks, powder with plain flour and seal in the heavy based pan. Again add to the slow cooker.

Deglaze the pan with red wine, adding the contents of the pan to the slow cooker. Cube 5 carrots and 3 potatoes. Place the veggies together with a 500gm serving of button mushrooms into the slow cooker.

Pour in more red wine and 2 cups of beef stock.

Slow cook for 4 hours or until the meat starts to fall apart. Serve in bowls with crusty bread and a strong Shiraz.

Feeds 6 and costs about $30. (Remember the economy is slowing, you may need this recipe)

Regards

Marcel Knesl

mknesl@oceaniaoncology.com

HIGHLIGHTS in this issue:

GO TO PAGE 35 FOR DETAILS OF SCLMA CLINICAL MEETINGS FOR REMAINDER OF THIS YEAR

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HEALTH SERVICE LINK - July 2015

Kevin Hegarty

This State Budget announced on 14 July contained a number of significant funding allocations to ensure the timely development and opening of the Sunshine Coast Public University Hospital (SCPUH).

It is important to separately highlight the various funding components:

Transitional funding - total allocation of $193.5 million of which $47.2 million is in this financial year (2015/16)
This funding will allow us to complete the planning for services at the SCPUH. Importantly, it includes funds to recruit and on-board the necessary staff in time for the SCPUH to open in November next year. This funding also covers all of the change management and other preparation work required to ensure that from day one the SCPUH will provide safe, high quality patient care and that the other hospitals within the SCHHS continue to provide services to our community.

Capital funding – within the overall total SCPUH Project capital allocation of $1.872 billion an amount of $488.7 million has been allocated for 2015/16.
This year's capital budget allocation is the planned and required amount to meet all of the commitments to advance the actual construction of the building of the new hospital, in line with the overall project plan. This ensures that the hospital construction will continue to be on time, ready for opening next year.

Nambour General Hospital
In order to specify in detail and prepare the required Business Case, $1.2 million has been allocated to plan the required refurbishment of Nambour General Hospital in order to make it fit for purpose for its role post the opening of SCPUH. This will include redevelopment of mental health wards and the creation of a purpose built rehabilitation unit.

Caloundra Health Service
Caloundra has been included in an overall $180 million Enhancing Regional Hospitals Program. This will enable Caloundra to be reconfigured for its role post the opening of SCPUH.

Information and Communication Technology funding
Queensland Health has allocated $9 million as initial funding for a range of ICT initiatives and upgrades. Additional funding has also been highlighted and approval processes are underway.

Importantly whilst not specifically announced in the Budget the provision of an **operating budget for SCPUH** has also now been further advanced. The Forward Estimates for the DoH now include an allowance for the SCHHS to deliver the required level of health services across all of its facilities, including the new SCPUH, from its opening in November 2016. (The Forward Estimates provide formal indication of budget provision for the next three financial years past the current one).

Australian Council of Healthcare Standards (ACHS) periodic review

From 2 - 5 June the Sunshine Coast Hospital and Health Service (SCHHS) was subject to a periodic review by the ACHS. I am keen to share with you feedback that we received at the Summation Conference conducted by the five ACHS surveyors.

All of the surveyors went to great lengths to express their shared view that our organisation is one that is genuinely committed to the provision of quality, safe health care. The recommendations from our previous survey were all closed with the exception of one that is in progress and relates to the physical modification of an inpatient area in mental health.

The surveyors indicated that they will be recommending to ACHS, that seven of our ratings in a number of standards be upgraded to 'meritoriously met'.

Whilst the summary provided needs to be formalised in an issued report by ACHS, we are entitled to pause and reflect on what is a very significant achievement. In twenty years I have never been party to a summation conference where every comment made by a surveyor was of a positive or extremely positive nature.

The quality of staff that work in the SCHHS is the reason that we have achieved this outstanding assessment.

Kevin Hegarty
Health Service Chief Executive, Sunshine Coast Hospital and Health Service
Kevin.Hegarty@health.qld.gov.au

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AMA QUEENSLAND PRESIDENT'S REPORT

Dr Chris Zappala

Dear members,

The release of the Queensland Budget 2015-2016 brought a trove of welcome announcements, including several explicitly called for in Part 1 of the AMA Queensland *Health Vision* and through our 2015 Election Platform.

Among the triumphs was the announcement of $7.5 billion towards the establishment of a state-wide Health Promotion Commission aimed to develop a whole-of-government healthcare plan.

A key function of the Commission will be to address and prevent the chronic illnesses that are so prevalent in our society and causative among re-admission events. It is disconcerting that at a time where our access to health knowledge and quality care is unprecedented, we are plagued with increasing rates of preventable disease. AMA Queensland welcomes the Commission as a positive step to more effectively manage the burgeoning prevalence of chronic illness among our aging population.

Many members have voiced grievances about the archaic IT systems present in various facilities across the state (HBCIS is steam driven), and we are pleased the Budget allocates $179 million to hospital ICT infrastructure. Antiquated and insufficient IT systems create an added administrative burden for administrators and clinicians, which detract from the collective efforts in patient care. Time will tell exactly what systems will be implemented, but we hold sanguine expectations all Queensland public hospitals will have first-class IT systems to complement the first-class care being provided. This will obviously be a necessary prelude to a credible implementation of a useful integrated electronic medical record. As we near the full implementation of the ieMR at PAH and Cairns Hospitals later this year, such infrastructure will be crucial.

Whilst this Budget is not perfect, its incorporation of several of our key platforms demonstrates the Government's commitment to consultation in policy development and the positive change AMA Queensland can achieve through sensible, evidence-based advocacy. There is still work to be done. AMA Queensland has never wavered in its willingness and commitment to represents it's members, argue for professional improvements and health system reform that improves the care we can offer our patients. This is not a sententious statement or trite rallying call as suggested by political opponents – but rather a visceral strategic principle that permeates decision-making and priority setting within our Association.

I remain very concerned about expanding the scope of practice for allied health professionals following the government's adoption of a precarious nurse endoscopy model. This is a perfect example of obdurate policy that lacks clear evidence of improved patient outcomes or economic efficiency and attempts to inveigle doctors into an alliance with predatory collegiate combatants within the healthcare system whose ultimate goal is role substitution. The follies of such policies are highlighted as comic when the deficiency of nurses within the system is recalled and the relentless complication of their work lives with administrative tasks made obvious.

A quality health system is contingent on a well trained workforce with clear duties, responsibilities and goals. Medical practitioners are the optimal professional with training and education to perform such procedures safely. Experience and knowledge go beyond the mere act of performing the procedure, but encompass the 'fringe' decision-making, acute procedural load, complication management and ability to settle on management plans with alacrity and agility. The health system is most efficient when health professionals seek to complement each other's roles, not substitute them, and we will continue to advocate for a system that sees all health services provided by professionals with the proficiency and training to perform them safely. Watch this space!

Sincerely,

Dr Chris Zappala, AMA Queensland President

WAYNE HERDY

AMAQ Councillor Report

AMAQ is having another look at the relationship between AMAQ and the several Local Medical Associations scattered around the state.

LMAs, or something like them, started as local sub-branches of the British Medical Association, long before the AMA took over from the BMA. Those ancient sub-branches bear little relation to the LMAs of today, their legacy being more closely reflected in the geographic areas currently represented by individuals on AMAQ Branch Council.

The LMAs as we see them today are the product of local initiatives driven by one or two individuals motivated by a need to unite the doctors within their natural catchment areas. Their purposes were more social than political, but they also adopted other roles including education and public advocacy. They were the natural channel of communication among professionals in confined areas, at a time when tools such as the internet were not even distant dreams.

Members of LMAs are not members of the AMA. Some LMAs have a high proportion of AMA members in their ranks, some have few. There is no provision for cross-membership.

Such small groups are inherently fragile, and can virtually cease to function or even to exist if the few individuals leading them choose to step down from the leadership. Some LMAs especially the Sunshine Coast, have developed such inherent strength that they look set to survive regardless of what any individuals choose to do.

LMAs suffered a serious blow with the emergence of Divisions of General Practice. Potential leaders (at least among the GPs) could choose between leadership roles in LMAs or in Divisions, but few had time to do both. In LMAs, they were working hard with no financial reward and little or no secretarial support to maintain coherence within a semi-interested group of fellows. In Divisions, they were working at a more relaxed pace, with reasonable financial reward and extensive secretarial support, to be the front personalities of groups of GPs who also had a financial interest in what the Division did for them.

Needless to say, the LMAs lost virtually half of their potential volunteer office-bearers, and lost a lot of ongoing interest from their GP members who had limited time for attending meetings. Many LMAs headed towards virtual oblivion.

A beneficial outcome of Divisions morphing into Medicare Locals and now into even larger conglomerates is that GPs looking for a genuinely local professional body have been turning back to LMAs. The demise of Divisions and the remarkably non-local character of Medicare "Locals" provide an emerging environment in which the moribund or latent LMAs might find new life.

Return our attention from the history to the current AMAQ interest. Some years ago an AMAQ President took a real interest in LMAs. Zelle Hodge initiated a monthly LMA Presidents' teleconference. It was surprising how many LMAs which had minimal membership and even less active participation were able to nominate a local President. This teleconference was a valuable communication tool, and a mutual support society. The LMA Presidents were able to compare notes on issues of concern to their members and obtain support knowing that other LMAs shared similar issues. The AMAQ President was able to nurture personal relationships with the local Presidents, and obtain grassroots feedback on what issues were of real importance to the members. Regrettably, subsequent AMAQ Presidents did not see the value of maintaining a regular two-way dialogue with those at their respective coalfaces.

About five years ago, when the LMA Presidents teleconferences were still alive, I initiated a drive to re-energize the moribund LMAs by creating an internal communication tool, their own Newsletter. I proposed to use an existing contractor to adapt a generic Newsletter, add local material, and hopefully use advertising revenue to make it self-funding. What that enterprise lacked was a central unifying management to sell the product to the LMAs and distribute the product to the potential membership of the renewed LMAs. I asked AMAQ to use its secretarial resources to deliver that platform. Unfortunately, by the time that plan was fully developed, the leaders in

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WAYNE HERDY

AMAQ Councillor Report / cont:

AMAQ had lost interest in LMAs and failed to see the benefits. With renewed interest by the current President, I hold some hope that AMAQ and the LMAs will join hands to support their respective members, especially those in smaller or more remote communities.

My fervent hope is that, once each LMA has a communication tool capable of reaching most of its potential members, they can become active with regular meetings and sharing of views. Especially away from the urban South-East corner of this vast state, it is very easy for doctors to become isolated, even with the internet and teleconferencing. LMAs are an ideal mutual local support network.

The AMAQ is interested for two main reasons.

Firstly, there is an undeniable potential membership benefit if the AMAQ can reach out to doctors who presently hardly even know that the AMA exists. In some rural areas, 85% of doctors are IMGs and many of those intend staying only a few years, so have little interest in their national professional organization. They still need a local support network. All should belong to a LMA. Some might end up joining the AMA, but only if the AMA is delivering what they need.

Secondly, the AMAQ stands to derive a benefit of even greater importance than membership. A close relationship with the LMAs will give the AMAQ a two-way channel of communication with the grassroots doctors, both AMA members and non-members. Knowledge is power. The AMA is often criticized, with good reason, of an ivory-tower mentality, of being out of touch with the everyday doctor-patient relationship. Knowledge of what is really happening in the workplace, whether at a regional hospital or in a single-doctor town, gives the AMA some real power to deliver what is needed by doctors, by patients, and by the wider Australian community.

I support the fostering of a closer alliance between the AMAQ and Queensland LMAs .

Dr Wayne Herdy.

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GPLO SCHHS - UPDATE JULY 2015

Dr Ranjit Paul

Hello all! I am temporarily standing in for Sandra whilst she is enjoying a life of leisure. Just a brief update on processes that continue in her absence.

1. Return of Specialist Referrals: A great deal of work has been undertaken between GPs and the HHS in developing referral pathways to assist patients in accessing appropriate specialist review in the most timely manner. However, it must be frustrating for GPs, who are of course only acting in the best interests of their patients, when a referral is returned as declined. Unfortunately at times the reason behind this is a lack of clarity of indication for the referral. The supporting guidelines are just that – guidelines. They do not prohibit appropriate referrals that specifically acknowledge deviation from guidelines accompanied by a clinical indication for this. The absence of such information makes it impossible to fairly triage a patient and may therefore delay or preclude their ultimate specialist consultation. I must thank GPs for support for the referral process and have attached the referral guidelines again for reference.
2. SPOT-ON Hospital Avoidance Program: The SCHHS in partnership with the Country to Coast PHN, QAS and others continues to explore processes and pathways that will need to be developed to support the pilot hospital avoidance program. Advertising has begun to recruit a support officer to co-ordinate and support the program's development and implementation. The programs clear aim is to direct patients of certain criteria to an appropriate non-hospital care provider. More updates to follow.
3. Clinical Prioritisation Criteria (CPC): Following on from Sandra's last update on CPC, field visits have been commenced to liaise with and inform GP practices in the community.

Sandra returns from leave on Monday 03 August and will continue the great work that she does (Ph: 07 5470 6541; email: sandra.peters@health.qld.gov.au). Drs Zoltan Bourne and Jon Harper are available every Tuesday at PHN Country to Coast : zbourne@phncountrytocoast.org.au and jharper@phncountrytocoast.org.au

Regards,
Dr Ranjit Paul, Senior Medical Officer, Caloundra Hospital Emergency Dept

INTRODUCING NEW MEMBER ..... Dr Anders Faber-Swensson, Gynaecology

Originally from Norway, Dr Faber-Swensson moved to Australia to complete his medical degree in Newcastle before moving to Queensland to train further in Obstetrics and Gynaecology. He was awarded his FRANZCOG qualification after training at several Queensland hospitals, including three years at Nambour General Hospital.

Dr Faber-Swensson is trained in all aspects of Gynaecology and Obstetrics, but has a special interest in infertility and laparoscopic surgery. He is committed to expanding and improving his knowledge in his speciality, and he was recently awarded a Masters of Reproductive Medicine by the University of New South Wales.

As a lecturer at the University of Queensland, Dr Faber-Swensson is actively involved in medical student teaching and assessments, and also has several publications resulting from research in the field of Obstetrics and Gynaecology.

When not working Dr Faber-Swensson enjoys spending time with his wife and three young children going to the beach, playing piano and ukulele, and swimmng in the pool.

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CELEBRATION !!

Local indigenous artist Bruce Rivett produced this painting to celebrate the opening of Dr Wayne Herdy's new medical centre at Maud St, Nambour.

The story in the picture is the story of the crocodile's circle of life, the crocodile laying eggs and protecting them while still striving for her own survival.

Dr Herdy says that the theme of protecting and preserving the cycle of life is a fitting theme for a medical practice, and this picture brings together the ancient traditional stories with the modern practice of medicine.

Dr Herdy has a long track record of caring for indigenous patients, with numerous trips to remote communities in Central Australia and the Northern Territory. The new medical centre includes features specifically intended to make it friendly for indigenous patients.

Dr Herdy is honoured that his work has been recognized by members of the local indigenous community in this artwork.

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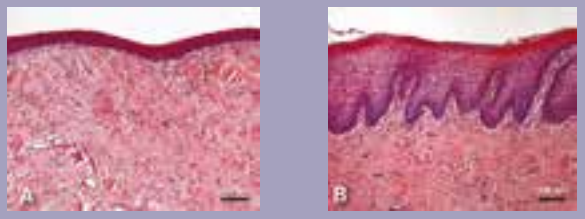

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- Ability to facilitate referrals for on-site MRI service and expedite referrals for ongoing treatment to the specialist of the GP's and the patient's choice.

UnitingCare Health

PHN COUNTRY to COAST REPORT - JULY 2015

Pattie Hudson

The first day of July marked the first day of operation for PHN Country to Coast, Central Queensland, Wide Bay, Sunshine Coast; the organisation tasked with taking over the responsibilities of the former Medicare Local regions of Central Queensland, Wide Bay and Sunshine Coast.

PHN Country to Coast opened its offices in Rockhampton, Bundaberg, Hervey Bay, Maroochydore and Gympie this month, ready to take on the task of addressing chronic disease, mental health, Aboriginal and Torres Strait Islander health, improving access to health care and supporting GPs and other health professionals to deliver health services that meet the needs of the diverse communities of the region.

PHN Country to Coast's dedicated Practice Support Officers will provide a range of services and support to assist general practices to value-add and enhance business operations. Depending on the requirements of the practice, support may include education and professional development; support to use clinical software more effectively; services to enhance chronic disease management; support and guidance when preparing for accreditation.

In collaboration with Hospital and Health Services across the region, PHN Country to Coast is establishing Community Advisory Councils and Clinical Advisory Councils, to ensure that all decisions made by the PHN truly reflect the needs of the communities they represent.

The GP-led Clinical Councils will also include a range of health care professionals, including nurses, specialists, allied health practitioners and Indigenous health workers, all at the coalface of health service delivery. The Council will utilise their skills and experience to advise the Board on decisions regarding the operation of the health care system for the region.

A key element of PHN Country to Coast's strategy will focus on population health planning.

PHNs will identify where there are areas of need, such as lack of health care services, difficulty in accessing these services, or regions with particularly high health needs, and work closely with GPs, allied health care providers, hospitals and the broader community to ensure that patients can receive the right care in the right place at the right time.

To that end, we have partnered with specialist international health and social sector consulting company, Abt JTA to establish the Planning, Evaluation and Research Unit (PERU).

PERU will manage the population health planning, monitoring and evaluation and research activities of PHN Country to Coast to ensure we are delivering services that demonstrate the most effective clinical benefit for our communities.

Planning, Evaluation and Research Unit (PERU).

Sharon Sweeney, Manager, Planning, Evaluation and Research Unit, Population Health Planner: Sharon has worked in the health and human services industries for over 28 years in roles within public sector, private sector (consulting) and non-government organisations. She has contributed to the development and delivery of the national cancer screening programs - BreastScreen Australia, the National Cervical Screening Program and the National Bowel Cancer Screening Program, and led the development of the prevention, screening and early intervention components of Queensland's State-wide Chronic Disease and Cancer Control strategies.

Dr Sanjoti Parehk, Epidemiologist:
Sanjoti is an epidemiologist with experience and expertise in programs focused on chronic illness, preventive medicine, community health care, use of technology in healthcare and integrating prevention strategies in primary care

Dr Elizabeth Holden, Monitoring and Evaluation Specialist:
Libby has a broad range of research experience including longitudinal research in women's mental health; health services evaluation research, particularly in chronic disease management; evaluation of research capacity building among primary health care professionals; health economics and health promotion research.

Karen Harmon AM, General Manager, Australian Programs, Abt JTA:
Karen Harmon is the General Manager, Australian Programs for Abt JTA. Karen has been involved in the health profession for some 40 years. She has tertiary qualifications in nursing, midwifery; health services management and international health development.

PHN Country to Coast is committed to a PHN that reflects the needs of the diverse communities that make up our region. We welcome feedback from health professionals and community members across the region. Please don't hesitate to contact us on info@phncountrytocoast.org.au or visit our website www.phncountrytocoast.org.au

Dr Janusz Bonkowski

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Dr Terry Coyne

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Dr Coyne visits SCUPH monthly and specialises in:

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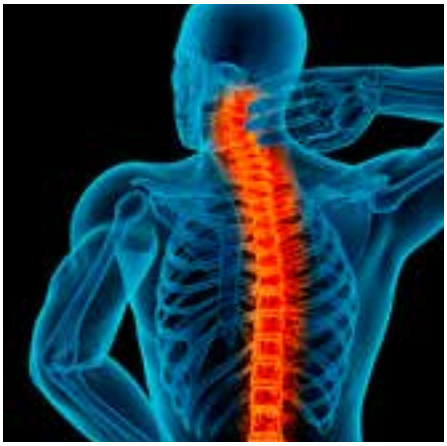

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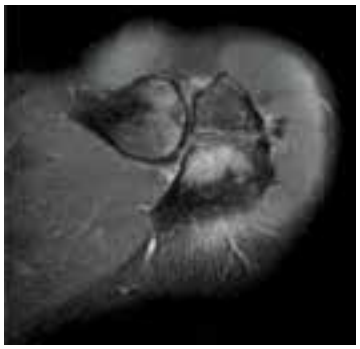
SUNSHINE COAST RADIOLOGY

OS Acromiale

Clinical history: A 28 year-old male with persistent shoulder pain and limited range of motion presents for MR imaging. Ultrasound revealed mild bursitis. FSPD axial and coronal images and sagittal T1W images are provided.

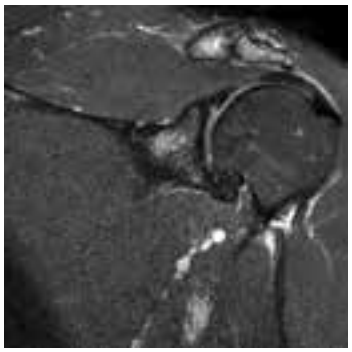


Diagnosis

Os acromiale.

MR Diagnosis

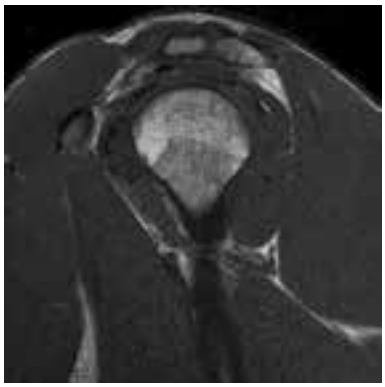
Admittedly, the diagnosis in this case based on only coronal and sagittal images is challenging. Indeed, the os acromiale, an un-united acromial ossification center in adults, is one of the most frequently missed abnormalities by physicians who interpret MR. The reason is two-fold. For one, the os acromiale, when viewed in the coronal or sagittal planes, bears a strong resemblance to a normal acromioclavicular joint. Secondly, the os acromiale is fairly common, being seen in approximately 8% of shoulder examinations. This combination of a not-uncommon, yet challenging finding, leads to the high frequency of missed diagnoses of the os acromiale.



It is essential in routine MR imaging of the shoulder to obtain axials that extend superior to a point above the level of the acromion. The key to the simple and reliable diagnosis of the os acromiale lies in these upper axial images. On such images, the acromion is completely visualized in the axial plane, and the diagnosis of an os acromiale becomes much simpler. Only in the axial plane is one able to reliably visualize both the AC joint and the os acromiale on a single slice.

Discussion

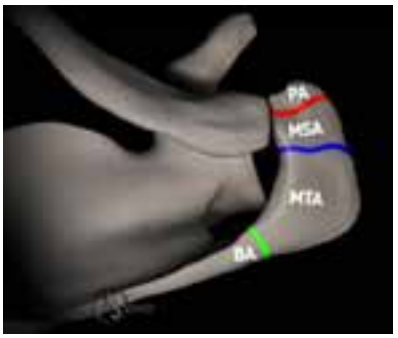
One to three ossification centers of the acromion appear by age 15-18 years, and they normally are fused no later than 25 years of age. Failure of any of these ossification centers to fuse results in an os acromiale. The three potential ossification centers are referred to as the preacromion, mesoacromion, and meta-acromion, from anterior to posterior. The adjacent ossification center for the lateral scapular spine is known as the basi-acromion. Failure of fusion can occur at the junction of any of these ossification centers, involving a single junction or in combination. As a result, there are 7 potential types of os acromiale that may arise.



The os acromiale has been implicated as a risk factor for the development of impingement syndrome, as in this case.It is important to realize that recognition of an os acromiale is necessary because the os itself may be a primary source of patient symptoms.

Treatment

If conservative measures fail over a period of 6 weeks to 6 months, operative therapy may be warranted. Preoperative recognition of an os acromiale is important in patients with impingement syndrome or rotator cuff tear, as an unstable os acromiale may render a typical anterior acromioplasty impossible. It is generally accepted that in patients with both an os acromiale and a tear of the rotator cuff, that the surgeon should correct both abnormalities. Neer reported that large os acromiales should be stabilized rather than resected at the time of rotator cuff repair, as resection of large fragments may lead to unacceptable weakness. Though not without controversy, such an approach remains popular with many orthopaedic surgeons.



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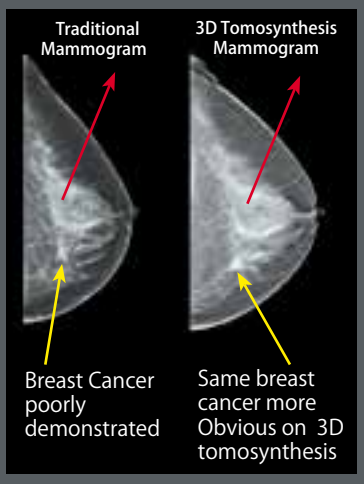

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Clinical patient trial for sacroiliac joint/ low back pain

DR BYRON ORAM AT PACIFIC RADIOLOGY is running the Australian limb of an international trial looking at the "effectiveness, safety and efficacy of Radiofrequency (RF) ablation of the sacroiliac joints in the treatment of chronic Sacroiliac Joint and/or dorsal sacral ligament pain, in well selected patients".

NOW ENROLLING

We are now recruiting for the study. Any patients between 18 and 85 years of age, with lower back pain for more than 3 months duration and unresponsive to non-interventional care, and who do not have a systemic inflammatory arthritis, may be eligible for enrolment.

All procedures and MRI scans associated with the study will be performed by Dr Oram, and will be bulk-billed. The risk with RF ablation is considered minimal, and potential benefits include substantial, long-lasting relief of their low back pain.

Please refer on our standard Pacific Radiology referral forms, with 'SACROILIAC JOINT RF STUDY' in the requested examination line. Your patient will then be contacted, and undergo an initial consultation to determine if they meet eligibility criteria for the study.

FURTHER IN-DEPTH STUDY INFORMATION IS AVAILABLE ON REQUEST.

For more information, call us on 5409 2800, or visit www.pacificradiology.com.au

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NON SURGICAL TREATMENTS FOR TENDON TEARS AND TENDON DISORDER

Tendon injuries are a common source of musculoskeletal pain in the population either as a result of an acute injury or as a result of repetitive trauma. These are common in the workplace and as a result of exercise and all forms of competitive and social sporting endeavours.

Initial treatments relate to attempts to reduce the initial swelling generally revolve around the use of rest, ice, elevation, analgesia etc. Some injuries do not respond to these measures and additional techniques such as physiotherapy, ultrasound therapy, technique modifications etc. may be required and it is this group that the injectable therapies are best targeted at.

A small number of people will benefit from more acute use of the injectable therapies and a small number of people, particularly for the shoulder will benefit from primary surgical repair in the first instance. These assessments are made by the referring doctor or physiotherapist in conjunction with imaging (usually ultrasound or MRI in conjunction with x-ray).

THE INJECTABLE THERAPIES

Steroids (cortisone)

Steroids have been the most widely used injectable agents over many years. They have a definite role in the treatment of acute inflammation e.g. Bursitis, Adhesive capsulitis/frozen shoulder, tenosynovitis.They can be used safely and effectively in that setting especially if imaging (usually ultrasound) guidance is used by an experienced practitioner.

Their role in the treatment of primary/acute tendon disorders which are usually partial thickness tears is becoming controversial because of potential issues relating to damage to the underling tendon.

This is primarily an issue when steroid is injected into the substance of the tendon (most likely to occur with non-guided/blind injections) and particularly in load bearing tendons such as the Achilles and Patella tendons where their use is contraindicated (not allowed). These concerns have led to a search for alternative injectable therapies worldwide.

Dry Needling

Dry needling/ultrasound guided fenestration of areas of tendon damage has been used for many years and is a proven effective treatment of chronic (not acute) tendon abnormalities. This forms the basis for all of the injectable therapies with considerable advances to this technique made by adding growth factors and anti-inflammatory mediators derived from your own blood. The use of whole blood (autologous blood injections) significantly improved the results of dry needling but as a result of the red blood cells contained in the whole blood these were quite painful.

Platelet Rich Plasma (PRP)

Platelet Rich Plasma uses the healing properties of your own blood to enhance healing. A small quantity of your own blood is taken from a vein usually around the elbow. This is centrifuged (spun) and separated into red blood cells and plasma. The deep layer of the plasma is targeted as this contains the largest concentration of platelets and their associated growth factors and anti-inflammatory mediators. It is these substances that promote tendon healing. One particular growth factor (TGF-beta) promotes scar tissue formation which is the explanation why PRP can sometimes work effectively in acute partial thickness tendon, muscle, and ligament injuries.

Our own local data and overseas studies suggest significant clinical improvements of around 80% in appropriately selected patients. This is a significant improvement over dry needling, autologous blood and because it is your own blood there are none of the side effects of tendon damage that can occur with steroids especially with repeated injections. This means there is no problem repeating the injection if it is required and many researchers do recommend more than one injection especially if there has been incomplete response.

Orthokine

Orthokine is obtained and used in a similar manner to PRP from your own blood. It is most widely used in the treatment of cartilage disorders and Osteoarthritis, injected into a joint, but it is also used in the treatment of tendon, muscle and ligament disorders. In addition to the centrifuge (spinning) procedure the blood is incubated in a special glass syringe with glass beads and then frozen. This leads to concentration of interleukin-1 receptor antagonists which are potent anti-inflammatory mediators. This means that Orthokine can be used in the same way as PRP but has slightly more pronounced anti-inflammatory activity and is the least likely to induce any inflammatory reaction at the injection site (although this is very uncommon regardless).

Tenocyte therapy

Most sophisticated percutaneous therapy whereby a biopsy (sample) is obtained from a normal tendon in your body (usually around the knee) and sent to the Orthocell laboratory in Perth, Western Australia where tenocytes (tendon cells) are cultured (grown). These are then sent back to us and we can inject the area of tearing with the tenocytes using ultrasound guidance. There is more expense associated with this procedure and a delay as the cells are cultured (grown).

Many niggling soft tissue injuries especially those that have not responded to other non-surgical treatments may now be able to be treated with injectable therapies which are both safe and effective.

For further information or if you would like to make a booking, please contact Pacific Radiology on 07 5409 2800

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MEDICAL MOTORING
with Dr Clive Fraser

"Built like a Tank!"

Built like a Tank!

As a child growing up in Brisbane I have wonderful memories of visits to the Queensland Museum at Bowen Hills.

They had butterflies, shrunken heads and a real live lungfish.

But, best of all they had the only surviving WW1 German A7V tank, affectionately called "Mephisto".

The name was presumably from Mephistopheles, a demon in German folklore.

The tank was captured by Australian forces (mainly Queenslanders) in 1918 at Villers-Bretonneux and the Aussie troops had to don gas masks when the Germans deployed chlorine gas.

Although Mephisto was destined for the British Imperial War Museum it somehow ended up in Brisbane and Queensland has been its home ever since.

It isn't operational, but as a child I always wondered how such a big lump of metal could move?

One of the most endearing comments that you can make about a car is to say that, "It's built like a tank".

That comment implies that the car is solid, reliable and unbreakable and is entirely positive so long as you don't say that the car drives like a tank too!

So it was with much fanfare that Russia recently unveiled a new vehicle which wasn't made by Avtovaz, Avtotor or Avtoframos.

It wasn't a Lada and yes it could easily claim to be built like a tank, because it was, "a tank".

It was Russia's all new T-14 Armata tank which was due to be show-cased to the world at a celebration in Red Square to mark the 70th anniversary of the end of the war against Germany in WW2.

Unfortunately, as the whole world now knows one of the T-14 tanks broke down for 15 minutes during a rehearsal and the driver poetically raised a red flag.

Just as well it wasn't deployed in a battle situation where a white flag would likely have been a safer option.

Whilst Australia will soon stop making cars, Russia will be hoping that there will be a queue of buyers for its latest piece of military hardware.

Selling armaments to the rest of the World is after all a very lucrative business and may help to pay for modernizing the old Soviet-era hardware.

Unlike automobiles where makers brag about how many kilowatts and air-bags their model has the specifications of the new T-14 will be a closely guarded secret for the foreseeable future.

Countries that sell weapons do tend to exaggerate their capabilities and are also inclined to leave out all the bells and whistles in models destined for export.

Who knows their customers might one day start shooting back.

But what is known about the Armata tank is that the turret is un-manned and controlled robotically.

That might mean that a fully robotic tank is not that far away.

It's 125mm gun is said to be smooth-bored and can fire missiles as well as shells.

That smooth bore gives the projectile a greater shell velocity and the barrel a longer life.

But tanks aren't all about who has the biggest err um, you know, long pointy thing.

They are a compromise between mobility (speed), armour and fire-power.

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In the case of anything made in Russia that equation might also need to include reliability.

Will the Queensland Museum ever house a captured Russian T-14 tank?

Well, maybe.

We do after all still have Mephisto!

Safe motoring

Doctor Clive Fraser

doctorclivefraser@hotmail.com

	Mephisto A7V	Armata T-14
First produced	1918	2015
Weight	33 tonnes	48 tonnes
Crew	18	3
Armour	15-30 mm steel	44S-SV-SH steel alloy
Main armament	57 mm gun	125 mm gun
Engine	2x4 cylinder 149 kW	12 cylinder X config 1120 kW
Speed	15 km/h	80 km/h
Range	80 km	500 km
Number produced	20	20

LATERAL HIP PAIN & PHYSIOTHERAPY

HIP Physiotherapist, Danielle has developed expertise in accurate diagnosis and treatment of low back and hip pain and regularly attends national and international conferences dedicated to these areas to stay up to date with research and current evidence for optimal patient care and positive outcomes. Danielle is very passionate about exercise rehabilitation and helping people return to their optimal physical and mental health through the use of Pilates. Danielle is experienced in identifying biomechanical dysfunction and using exercise specific techniques ensuring great outcomes.

For patients suffering from Lateral hip pain (**LHP**) the traditional diagnosis has been Trochanteric Burstis. However it has been demonstrated that Bursal enlargement / inflammation is not a consistent feature of LHP (Connel et al. 2003, Bird et al 2001, Silva et al 2008). There is instead evidence of gluteus medius/minimus tendonosis. (Dwek et al. 2005, Kong et al. 2007, Woodley et al. 2008). Tendon unloading strategies through relative rest and biomecianical correction are the mainstay of successful management.

Dani is based in Buderim & Kawana

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haemorrhoids, prolapse, incontinence, arthroscopy and rotator cuff tears

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Please join us for a night of interactive discussion.
Flag a topic – it's your night, so if you have a topic that you would like addressed please email it through.

LEARNING OUTCOMES:
Attendees will be able to:
- Update their approach to common anorectal conditions
- Identify a systems approach to management of incontinence and prolapse
- Understand the role of arthroscopy v TKR and be able to discuss with patients
- Understand the course of rotator cuff injuries in the older population

PROGRAM

6.15pm Dinner & registration

7.00pm Presentations & discussion

"It's my haemorrhoids Doc"
Dr John Hansen, *General Surgeon*

Prolapse and incontinence in women young and old
Dr Robyn Boston, Gynaecologist

Case discussions:
Arthroscopy vs total knee replacement: who gets what and when?
The incidence and progression of rotator cuff tears in the older population
Dr Luke McDermott, *Orthopaedic Surgeon*

9.00pm Evaluation & close

When:
Wednesday, 19 August, 2015

Where:
The Lakehouse Sunshine Coast,
15 Freshwater Street
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Mountain Creek Qld 4557

RSVP:
Friday, 14 August

Approved 4 Category 2 QI&CPD points

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or
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Email / call Pam if you wish to be removed from our mailing list

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DIRECT LIFE INSURANCE, NOT SO CHEAP

Today we are bombarded with direct insurance advertisements on TV and social media. Companies such as Real Insurance, Choosi, Suncorp and the most recent one Coles Insurance all claim to be the cheapest and easiest to apply. Coles even has a "Price Beat Guarantee" stamp on their Life insurance so it must be the cheapest right? Wrong.

Firstly, let's look at the price of these policies compared to a normal retail policy which can be offered through an insurance adviser. I am 30 years old, non-smoker and want $1MIL Life cover. Coles Life insurance will cost me $66.93 per month which includes their 20% discount if I am a frequent flyer member and Suncorp will cost me $81.98 per month for the same cover. If I apply with Suncorp I get a $50 gift card and 10% back on my premium every 3 years. When I compare this to a retail insurance policy with Asteron, $1MIL of Life cover will only cost me $45.87 per month. This is a premium saving of over 45% compared to Coles and a 70% premium saving compared to Suncorp, even though Suncorp owns Asteron. Even with Suncorp's 10% back every 3 years I will be around $350 p.a. better off with Asteron.

The second issue is policy ownership. All of the direct insurance companies are very limited as to who can own the policy and in most situations the policy must be owned by the life insured/self owned. The issue with this is that the premium then needs to be paid in after tax dollars out of the personal account and the premium is not tax deductible. This is opposed to retail insurance policies where I can own the policy through a Self Managed Super Fund (SMSF) or get any other superannuation fund I have (e.g. Q Super, Colonial First State, MLC, Sunsuper etc.) to pay for the premium. The premium then does not affect my personal cash flow, is funded by existing super fund account balance and/or employer contributions and the premium is a tax deduction to my super fund.

Applying for cover sounds so easy with direct insurers? Good marketing is the key as you normally only require a short form application which can be done over the phone or online. The maximum cover you can normally apply for is $1.5MIL with no blood tests or medicals. The reality with retail insurance policies is that you can apply for up to $2.5MIL with no blood tests or medicals if you are under age 45. The application can also be done over the phone with the insurance adviser for convenience. There is also no limit with the level of cover you can apply for with retail insurance. I myself have $2.3MIL Life cover as I have two young children, my wife is a full time mum and we have a mortgage. My premium is also funded by my Superannuation Fund. On this basis a direct insurance company would not meet my needs.

Finally and most importantly is the claims management. Who will handle the claim for your spouse or your estate if you pass away? I'm sure the 16 year old check out boy at Coles won't provide any assistance. Having an insurance adviser who provides a claims management service will ensure your claim is handled efficiently and professionally with the insurance company directly on your behalf which saves a lot of time and stress for the dependent family members.

For more information please don't hesitate to contact Hayden White (Risk Specialist) at Poole Group on **07 5437 9900** or hwhite@poolegroup.com.au.

PRIVATE
PRACTICE SERIES

AMA QUEENSLAND

Is Your Practice Sustainable?

Does your practice have the three Ps of sustainability? Profits, People & Professionalism

Wednesday 26 August, 9am - 12 noon
Mayfield House
3/ 29 The Esplanade, Maroochydore 4558

In addition to providing quality care, medical practitioners and practice managers must also navigate the complicated field of business and workplace management. If you have questions about finance, business management or human resources, this is a can't-miss workshop. Join Ken Lewis, AMA Queensland Workplace Relations Manager, as he shares and discusses with you some of his key insights into developing and managing a sustainable practice, canvassing compliant contracts and best-practice HR management. Co-presenting with Ken is Paul Copeland, Partner at William Buck accountants whose extensive experience in the medical industry covers all areas of general and specialist practices, assisting practitioners with accounting, tax and business advisory requirements.

Discounted member rates apply for member practitioners and their support staff. As a special offer members of the SCLMA are eligible for AMA Queensland member rates, just add the code "SCLMA" on the registration form when registering. Visit www.amaq.com.au to register or email **registrations@amaq.com.au** for a registration form

SPECIAL OFFER!

Use "SCLMA" on your registration form to receive exclusive AMA Queensland member rates

Who should attend?

- Health practitioners
- Practice managers
- Support staff
- Allied health

Workshop details

Inclusions: Tea/coffee on arrival, biscuits and course notes.

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O'LEARY WALKER - THE FUTURE IS CLARE

dr. plonk

You just know that the wine made by two passionate good mates with a pedigree and longevity in the wine game is going to be good. David O'Leary and Nick Walker had both been in the services of the large multinational wine teams and saw the need in 2000 for going back to hand crafted boutique styles.

Hence the birth of O'Leary Walker Wines .....

Both are Roseworthy Agricultural graduates and have shone since. David has worked for some of the big companies in Australia such as Thomas Hardy and Sons and Chateau Reynella and in France and California. 1988 saw him win the Jimmy Watson Trophy (best 1y dry red wine) and been awarded the International red wine maker of the year 92 and 94. Clare Valley Riesling has been a passion.

Nick has had great affinity with sparkling wine through Wolf Blass and Yellowglen. He is third generation winemaker and has had great affinity with Eden Valley Riesling. Together, they have received more than 300 gold medals and 60 odd trophies for wines. Amazing in just 14 vintages.

They work tirelessly in the vineyard, nursing their fruit like expectant Mothers. It always begins in the vineyard. 18000 cases of wines over 9 products are made with 70% of the vineyards owned by David and Nick. The shortfall is made from high quality growers from Adelaide Hills (Sisters Vineyards), McLaren Vale, The Barossa and Coonawarra.

The wines have always been value for money. They can't compete with the Corporates but don't really want to. The philosophy of "let's make great wine, give it some character and have some fun" echoes through to the end product. Unfortunately various taxes and rising transport cost are a threat to many a boutique wine maker.

Wines tasted ....

2010 Hurtle Sparkling Pinot Noir 70% Chardonnay 30% Adelaide Hills. Light golden yellow in color. The nose delicately unfurls its strawberries and cream nuances and hints of yeasty biscuits. The palate is flavorsome with a subtle acid and tannin effect. A very cleansing aperitif dry style. Will cellar for 5 years and be awesome.

2015 Watervale Riesling Clare Valley- light yellow with hints of green tinges. Lemon lime notes with mild oiliness fill the bouquet. A lush Riesling with great acid backbone; but not sweet. Awesome with raw Haloumi cheese.

2015 Adelaide Hills Sauvignon Blanc- Very pale yellow green. Hints of white peach with grassy floral notes. Good upfront palate with a very dry finish. Flathead or Jew fish fillets would suit.

2013 Cabernet Sauvignon Malbec Clare Valley- This is a new wine. Nice alluring purple red colors. Cassis fruits with violets and Cabernet dust. The nose evolves into the darker fruit spectrum. The fruit is generous with good tannin structure. The Malbec is a great edition filling in some anterior palate and adding floral notes. Organic Pork on the rib with celeriac mash went well. Cellar some 5 years

2012 Clare /McLaren Vale Shiraz. Garnet red with some ageing brown colors evident. The nose wafts dark stewed prunes, black olives and hints of tobacco. Great fruit in the anterior palate, that lingers and marries with subtle silky tannins. Venison and blackberry/juniper jus and mash.

Dr Plonk

CITTAMANI HOSPICE SERVICE

Celebrating
20 Years of Service on the Sunshine Coast

SPIRITUAL CARE *~ Bringing a Calm and Compassionate Mind to the Care of the Dying*

Friday 25th September, 2015

8.30am – 4.30 pm

Twin Waters Resort: Ocean Drive, Twin Waters, Qld

Cost: $120 / Concession $80

Guest Speakers

Geshe Puntsog was born in Tibet and at age 14 was admitted to Sera-Je Monastery in South India. Geshe-la is now teaching at Chenrezig Institute on the Sunshine Coast, however, before coming to Australia he cared for his own spiritual teacher through his dying process.

TY Alexander has been a student of Buddhism since 1974. She spent many years studying in India and Nepal and was an ordained Buddhist nun for about 9 years. She currently leads retreats and courses in Buddhism, and has a particular interest in Mindfulness meditation.

Tenzin Chodron is a Buddhist nun who has worked in spiritual care at Karuna Hospice, Brisbane, for the past 14 years. She has many years experience as a social worker and counsellor. In addition to her work in this area, Chodron regularly conducts courses and retreats on spiritual care.

Trish Wilson is a registered nurse, midwife and counsellor. She currently coordinates the Bereavement Support Program at the Mater Mothers' Hospital in Brisbane. She holds a deep respect for the sacredness of life and living, and for the strength of the human spirit in adversity.

Jane Hutton is a social worker and narrative therapist with around 30 years experience. She offers counselling and supervision, and runs community workshops in narrative therapy. She also lectures on narrative therapy both within Australia and overseas.

www.cittamanihospice.com.au

Enquiries & Bookings: noela.cittamani@gmail.com

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Dubai, UAE – The Land of Extravagance

Dubai, also called as Dubayy in Arabic is one of the seven Emirates of the United Arab Emirates and the second largest town after Abu Dhabi. If you want to experience luxury and extravagance with a variety of things to do and see, head to Dubai!

The Enchanting Dubai

Popular for its man-made island, Palm Jumeriah, huge skyscrapers with the world's tallest building, Burj Khalifa, the city to have the seven star hotel, Burj-al-Arab, the luxurious yachts on the magnificent gulf coastline, and the very popular Dubai shopping festival, make it a destination for splendid holidays. Not just this, the city offers an easy way in to the Desert vegetation all around for you to watch the breathtaking sun sets across the sand dunes. When you are done with clicking sunsets and camels, move to some of the world's best restaurants in Dubai to stir up your taste buds! Well, what is travel without good food?

What have we got for you in Dubai?

1) Take the glimpse of Dubai skyline from the tallest building in the world. **Burj khalifa,** a man-made wonder, and beautifully constructed by 13,000 workers who worked day and night and completed each level in about only three days. There are two observation decks, the 128th floor and the 148th floor. For those who want to skip the line and see the skyline from the highest observation point, are taken to the 148th floor with the "sky-ticket". Includes Arabian refreshments, a guided tour and an interactive screen.

2) **4x4 Desert Safari** is a must-do thing on your Dubai trip and we ensure you do not miss the golden sun kissed dunes, the magnificent views of the desert and incredible sunset. While you are taken to the desert, you get to hear the interesting tales of the region from the driver as you enjoy the hoard of camels passing by you. The desert in itself is fascinating; however, it gets even better when you are served with barbecue dinner. A lot is packed in there for you like henna tattoo, camel rides, belly dance performance around the campfire and the heady shisha (Hookah) to end the evening with bliss and contentment.

3) A visit to **gold souk,** whether you want to buy gold or not is a must visit place just to see how much gold a city of Dubai can showcase! Gold worth million dollars in the form of jewellery is displayed in shops for people to buy at comparatively low rates.

4) Who does not love beaches? Guess, everyone! A visit to Jumeriah Beach Park, the longest beach in Dubai with silver sands gives a day to relax and rejuvenate amid Sun, sand and sea.

5) Meet the lovely dolphins at the **Dolphin Bay in Atlantis**. Interact and play with these gorgeous water creatures or just watch them with amusement as they show their skills in the water. Be friends with dolphins as you touch, hug and kiss them, an activity memorable for people of all ages!

How are things planned for you?

We have developed an interesting and comprehensive itinerary for you that include all the fascinating attractions and interesting things to do:

- *Trip to Burj Khalifa to experience the Dubai Skyline*
- *A visit to Dubai Mall that has high end fashion stores and plenty of American and other food chains catering to people from all kinds of backgrounds and tastes. It also has one of the largest aquariums of the world with 33000 aquatic animals. Surely a delight to see those colourful creatures!*
- *Trip to Atlantis, a gorgeous hotel with plenty of things to do and see. You can interact with dolphins, enjoy with your kids at the water park or perhaps just enjoy the glorious architecture.*
- *Shopping trips to Gold Souk and Madinat Souk*
- *For a relaxed day out, we take you to Jumeriah Park Beach in the day and on an exciting boat cruise trip at the Dubai creek with dinner and drinks in the evening*
- *Not to forget, a desert safari is a part of this exciting itinerary that takes you to the gorgeous sun baked desert and gives you a true Arabian experience in Middle East.*

Indulge yourself lavishly in this beautiful city of extravagance.

123Travel Shop 5/56 Burnett Street Buderim

EIGHTEENTH ANNUAL GENERAL MEETING
The Sunshine Coast Local Medical Association Inc.
THURSDAY 27 AUGUST 2015
Maroochydore Surf Club Function Room

AGENDA

Business:

1 Chairman's opening remarks
2 Apologies
3 Minutes of previous Annual General Meeting, 28 August 2014
4 Business arising from previous minutes
5 President's report
6 The presentation of the statement of income and expenditure, assets and liabilities and mortgages, charges and securities affecting the property of the SCLMA for the last financial year
7. The presentation of the Auditor's report on the financial affairs of the LMA for the last financial year
8. The appointment of an Auditor/Accountant
9. The election of members of the Executive Management Committee
10. General Business:

Close

Wayne Herdy
Honorary Secretary

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SUNSHINE COAST LOCAL MEDICAL ASSOCIATION Inc.

ANNUAL GENERAL MEETING

Thursday 27 August 2015

MAROOCHYDORE SURF CLUB

NOMINATION FORM

for the SCLMA Management Committee

Nominations are to be proposed by a financial member of the Association, seconded by one other financial member of the Association, and accepted by the nominee.

POSITION: _____

NAME OF NOMINEE: _____

PROPOSER: _____

SECONDER: _____

I, _____

agree to this nomination (please sign)

RSVP: Monday 24 August. Fax to: 5479 3995

or post to: SCLMA PO Box 549 Cotton Tree 4558

Seventeenth Annual General Meeting
The Sunshine Coast Local Medical Association Inc.
Thursday 28 August 2014
Maroochydore Surf Club Function Room

(DRAFT) MINUTES

(to be accepted at the AGM 27 August 2015)

Meeting opened at 7.15 pm by the President, Dr Di Minuskin

BUSINESS:

1. **Chairman's opening remarks: Jo Bourke**

2. **Members present: (54)**

   Drs John Adkins, Kevin Barker, Trevor Beall, George Bogiatzis, Robyn Boston, Jo Boyton, Fabio Brecciaroli, Marlene Clout, Michael Cross, John Evans, Vince Flynn, Raouf George, Bruce Goldshaft, Stan Green, Jenny Grew, Adrian Guest, Wayne Herdy, Kirsten Hoyle, Rob Ingham, Raewyn James, Stephen Kettle, Jugal Kishore, Sabi Kishore, Marcel Knesl, Edwin Kruys, Jerome Lai, Seb Lambooy, Chris Lambooy, Daniel Lane, Kelvin Larwood, Jonathan Last, Chris Lonergan, Scott Masters, Brian McDonnell, Di Minuskin, James Moir, Alison Morris, Byron Oram, Trish Pease, Joanna Perry-Keene, Janette Ritchie, Peter Ruscoe, Andrew Southee, Andrew Spall, Mason Stevenson, Piotr Swierkowski, Jeff Tarr, Karien Treurnicht, Stacey Wirth, Peter Zwoerner, Jon Steinberg, Clive Fraser, Peter Jacobs, Jeremy Long, Sandra Peters, Michelle Lien.

   Apologies members: (29)

   Drs Bob Anderson, Wendy Bourke, Geoff Byrne, Noel Cassels, Mark Coghlan, Ian Colledge, Justin D'Arcy, John Fogarty, Peter Georgius, John Hansen, Caroline Hughes, Fran Johnson, Sybil Kellner, Irene Krajewska, Wyn Lewis, Bill Meyers, Paul Munchenberg, Peter Nash, Heather Parker, John Reardon, Edward Street, Mark Welsh, Melissa White, Rohan Wilmott, Peter Winstanley, Denise Ladwig, Clem Nommensen, Scott Masters, Kim Latendresse.

3. **Minutes of previous Annual General Meeting, 22 August 2013:**

   Motion - *'that the Minutes of the Annual General Meeting, 22 August 2013 be accepted'*

   Moved: Dr Wayne Herdy. Seconded: Dr Peter Ruscoe. Carried.

4. **Business arising from previous minutes: Nil**

5. **President's report delivered by Dr Di Minuskin.**

6. **Treasurer's report delivered by Dr Peter Ruscoe:**

   The presentation of the statement of income and expenditure, assets and liabilities and mortgages, charges and securities affecting the property of the LMA for the last financial year.

   Dr Ruscoe reported that current membership is 320. It is expected that the annual subscription rate will stay at the discounted rate of $55.

   Dr Peter Ruscoe moved - *'that the Treasurer's Report be accepted'*

   Seconded: Dr Kevin Barker. Carried.

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7. The presentation of the Auditor's report on the financial affairs of the LMA for the last financial Year:

Dr Peter Ruscoe moved – *'that the Auditor's report be adopted'.*

Seconded: Dr Stephen Kettle. Carried.

8. The appointment of an Auditor/Accountant:

Dr Peter Ruscoe moved *'that Smart Steps Accounting be approved as the Auditor for the following financial year.*

Seconded: Dr Kevin Barker Carried.

9. The election of members of the Executive Management Committee.

The nominees for positions for 2014 - 2015 were as follows:

ROLE	NOMINEE	PROPOSER	SECONDER
President	Dr Di Minuskin	Dr N Sommerfeld	Dr R Ingham
Vice President	Dr Rob Ingham	Dr D Minuskin	Dr D Ladwig
Secretary	Dr Wayne Herdy	Dr D Minuskin	Dr P Ruscoe
Treasurer	Dr Peter Ruscoe	Dr M Stevenson	Dr D Minuskin
Comm & Newsletter Editor	Dr Marcel Knesl	Dr K Hoyle	Dr S Phipps
Comm & Meetings Convenor	Dr Scott Masters	Dr P Ruscoe	Dr D Minuskin
Comm & Hospital Liaison	Dr Jeremy Long	Dr P Ruscoe	Dr D Minuskin
Committee	Dr Kirsten Hoyle	Dr M Knesl	Dr S Phipps
Committee	Dr Mason Stevenson	Dr D Minuskin	Dr R Ingham
Committee	Dr Nigel Sommerfeld	Dr D Minuskin	Dr R Ingham
Committee	Dr Byron Oram	Dr P Ruscoe	Dr D Minuskin
Committee	Dr Denise Ladwig	Dr K Hoyle	Dr S Phipps
Committee	Dr Jenny Grew	Dr J Adkins	Dr K Hoyle

All nominees were elected unopposed.

10. General Business: Nil

Incoming President Dr Di Minuskin thanked the outgoing committee and congratulated all elected committee members especially new member Dr Jenny Grew. She expressed her desire for a productive year ahead for the Association.

The meeting ended at 7.30 pm

Wayne Herdy

Honorary Secretary

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SUNSHINE COAST LOCAL MEDICAL ASSOCIATION
MANAGEMENT COMMITTEE MEETING
THURSDAY 28 MAY 2015
Maroochydore Surf Club Function Room, Maroochydore
MINUTES
(Accepted at Committee meeting 25 June 2015)

Attendance: Drs Di Minuskin, Rob Ingham, Kirsten Hoyle, Marcel Knesl, Byron Oram, Scott Masters, Denise Ladwig and Jo Bourke (Observer)

Apologies: Drs Wayne Herdy, Scott Phipps, Jenny Grew, Jeremy Long, Peter Ruscoe and Peter Dobson.

Minutes of last meeting: 23 April 2015
The Minutes were accepted as a true and accurate record.
Moved: Di Minuskin. Seconded: Peter Kirsten Hoyle. Carried.

Business arising from Minutes. Nil.

President's Report: *Dr Di Minuskin.*

1. Budget news: Concern over where the savings in health will come from. Essential that changes are made in consultation with clinicians;
2. Concern re reported shortfall in funds for the running costs of SCUH;
3. Some news from NGH: Pilot program for summaries of DEM attendances to be sent via MO to GPs. Trialled in Gympie, then a month later in Caloundra and then Nambour if successful. Dermatology, although a relatively new services, is already looking at long waiting periods. Considering where clinically appropriate, review photos with Ix and referral and suggest management plans. If the treatment is unsuccessful patient will still be seen without them 'losing' their place on the waiting list;
4. Hospital avoidance pilot about tot be trialled. QAS assessed 'GP" level patients to be taken directly to the doctor's surgery;
5. After-hours changes: Five levels of payment being suggested.

Vice President's Report : *Dr Rob Ingham – Nil.*

Secretary's Report: *Dr Wayne Herdy - Apology*

Correspondence In: *(tabled Jo Bourke, Secretariat)*

- Insurance Advisernet – Renewal of Business Insurance Policy

Correspondence Out: Nil

Business arising from Correspondence: Nil

Treasurer's Report : *Dr Peter Ruscoe – Apology.*

Accounts to be paid:
- Australia Post – Account April 2015
- Jo Bourke – Secretariat April 2015
- Jo Bourke – Newsletter May 2015
- Snap Printing – Newsletter May 2015
- Snap Printing – Invites May 2015
- Jo Bourke – Adobe CC subscription April 2015
- AMAQ Insurance – Business Insurance Policy

Moved: Di Minuskin that the accounts be paid.
Seconded: Kirsten Hoyle. Carried.
(b) Membership Report.
Dr Rob Park (GP Buderim)

Moved: Scott Masters. Seconded: Byron Oram.
Application accepted.

AMAQ Councillor's Report: *Dr Wayne Herdy - Apology*

Meetings Convenor Report: *Dr Scott Masters*

- Decisions have been made re date and venue for SCLMA Christmas in August;
- Date: Saturday 8th August. Venue: The Outrigger, Noosa Heads.
- Monthly clinical meeting 25 June to be held at Ebb Restaurant.

Hospital Liaison Report: *Dr Jeremy Long – Apology.*

Medicare Local Report: *Peter Dobson – Apology.*

General Business: Nil.

Meeting Close: 1900

Next meeting – Thursday 25 June 2015 - Ebb Waterfront Restaurant.

Acting Secretary
Jo Bourke.

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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.***

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Take Five .....

Man reports missing wife

A man went to the sheriff's department to report that his wife was missing.

Husband: My wife is missing. She went shopping yesterday and has not come home...

Sergeant: What is her height?

Husband: Gee, I'm not sure. A little over five-feet tall.

Sergeant: Weight?

Husband: Don't know. Not slim, not really fat.

Sergeant: Color of eyes?

Husband: Sort of brown I think. Never really noticed.

Sergeant: Color of hair?

Husband: Changes a couple times a year. Maybe dark brown now. I can't remember.

Sergeant: What was she wearing?

Husband: Could have been pants, or maybe a skirt or shorts. I don't know exactly.

Sergeant: What kind of car did she go in?

Husband: She went in my truck.

Sergeant: What kind of truck was it?

Husband: A 2015 Ford F150 King Ranch 4X4 with eco-boost 5.0L V8 engine special ordered with manual transmission and climate controlled air conditioning. It has a custom matching white cover for the bed, which has a matching aftermarket bed liner. Custom leather 6-way seats and "Bubba" floor mats. Trailering package with gold hitch and special wiring hook-ups. DVD with full GPS navigation, satellite radio receiver, 23-channel CB radio, six cup holders, a USB port, and four power outlets. I added special alloy wheels and off-road Michelins. It has custom running boards and indirect wheel well lighting.

Then.....at this point the husband started choking up.

Sergeant: Don't worry buddy. We'll find your truck!!!!!!!!!!!!!!!!!

Pensioner's story re Tesco

Yesterday I was at my local Tesco store buying a large bag of Chum dog food for my loyal pet and was in the checkout queue when a woman behind me asked if I had a dog..

What did she think I had, an elephant?

So, since I'm retired and have little to do, on impulse I told her that no, I didn't have a dog, I was starting the Chum Diet again. I added that I probably shouldn't, because I ended up in hospital last time, but I'd lost 2 stone before I woke up in intensive care with tubes coming out of most of my orifices and IVs in both arms.

I told her that it was essentially a perfect diet and that the way that it works is to load your pockets with Chum nuggets and simply eat one or two every time you feel hungry. The food is nutritionally complete so it works well and I was going to try it again.

(I have to mention here that practically everyone in queue was now enthralled with my story.)

Horrified, she asked me if I ended up in intensive care because the dog food poisoned me. I told her no, I stepped off the kerb to sniff a good looking dog and a car hit me.

I thought the guy behind her was going to have a heart attack he was laughing so hard. I'm now banned from Tescos.

Better watch what you ask retired people. They have all the time in the world to think of daft things to say.

"There is a fountain of youth: it is your mind, your talents, the creativity you bring to your life and the lives of people you love. When you learn to tap this source, you will truly have defeated age."

— Sophia Loren

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"

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CLASSIFIEDS

FEMALE VR GP REQUIRED

- For a not for profit Women's Clinic in Mooloolaba offering family planning type services.
- Hourly rate, work at your own pace.
- Fully computerised using BP software.
- Full time nurse support. Work days and hours flexible. No weekend or after hours.
- The opportunity also exists to be involved in decision making and goal setting for the clinic. The practice has DWS approval.

For more information contact Practice Manager, Wendy Stephenson, on womenshealthcare@bigpond.com or Ph: 0416 938 040 or 5444 8077

July 2015

DR LYDIA PITCHER

Paediatric Haematologist / Clinical Haematologist

Welcoming new patients at Sunshine Coast Haematology and Oncology Clinic
10 King Street, Buderim

Dr Pitcher is a paediatric haematologist, with dual fellowships in paediatrics and pathology (haematology), and extensive clinical and laboratory experience in blood disorders in children and young adults.

To arrange an appointment, or make enquiries,
Phone : 5479 0000
Email : reception@schoc.com

July 2015

GP OPPORTUNITY

- General Practitioner wanted to join our friendly team at Better Health on Buderim on the beautiful Sunshine Coast.
- A choice of sessions are available mornings and afternoons Wednesdays, Thursdays and Fridays, and in the afternoon Mondays and Tuesdays. There is a rotating roster for Saturday mornings.
- We offer a CDM nurse, full nursing support and a fully equipped treatment room.
- The practice is accredited and fully computerised using Best Practice. We are a mixed billing practice. Our current consult 23 fee is $75.90 with the practice charging a 35% management fee.

For further information please call Nicola on (07) 5456 1600 or email pm@betterhealthonbuderim.com.au

July 2015

Classifieds remain FREE
for current SCLMA members.
$110 for non-members
Ph: 5479 3979. Mobile: 0407 037 112.
Email: jobo@squirrel.com.au
Classifieds remain on the list for 3months.

GP OPPORTUNITY -
BRAND NEW PRACTICE IN NAMBOUR

Dr Wayne Herdy has moved from Ann St Family Medicine, Nambour to Maud Street Medical Centre, 7/1 Maud Street, Nambour (next door to Centrelink and Medibank).
Dr Herdy is already booked out!
Hours and financial arrangements flexible.
Contact Kelly Howard, practice manager:
Ph: 5491 5666.

CHANGE OF ADDRESS -
DR ANDREW SOUTHEE

After 20 years at Sunshine Coast Private Hospital rooms Northcoast Nuclear Medicine has moved to: Shop 5, 12 King Street, Buderim (co-located with QDI) Noosaville rooms have also relocated to: Noosa Hospital, 111 Goodchap Street, Noosaville (co-located with QDI)
Contact details remain the same:
All Bookings: Ph: 5478 2037
Fax Referrals to: 5444 7816

DR T K HO - RETURN TO WORK

Just a quick note to let our local medical colleagues know that I have made recovery from my injury last year and been back at full time work since February including full operative duties.

My consultation rooms are at:

- 31 Second Avenue, Maroochydore
- 2 Caloundra Road, Caloundra
- **Ph: 5443 9999** for all appointments
- Visit our Website: www.ortho-drho.com.au

Dr TK Ho, Orthopaedic Surgeon

May 2015

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

THURSDAY 27 AUGUST 2015

'Chromosomal Microarray : molecular karyotyping for pre-natal, constitutional and cancer care'
Speakers:

- Nicole Chia, Genetics Manager, QML Pathology
- Dr Sybil Kellner, Medical Oncologist
- Dr Jenny Grew, Pathologist

Sponsor: QML Pathology
Venue: Maroochydore Surf Club.

NOTE: THE ANNUAL GENERAL MEETING WILL BE HELD AT THIS MEETING.

THURSDAY 24 SEPTEMBER 2015

Speakers: From Nambour General Hospital
Topic: Research Now & for the Future
Venue: Maroochydore Surf Club.
Sponsor: To be advised.

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

SCLMA CLINICAL MEETING - 25 JUNE 2015

Ebb Waterfront and Dining Restaurant, Maroochydore

Dr Stuart Collins - *'Urolift - a Novel Treatment for Male Lower Urinary Tract Dysfunction*

Dr Susan Perel - *'Optimising Treatment in Allergic Rhinitis"*

Sponsors: Urolift and Meda Pharmaceuticals

Sponsor Kim Caffery from Meda with Dr Susan Perel, Presenter.

Presenter Dr Stuart Collins with Libby Colquhoun, Sponsor from Urolift

Dr Kevin Farrell with Dr Paul Munchenberg

Dr Susan Perel, Patrick Beall, Dr Clive Fraser and Dr Trevor Beall

Dr Lisa Knesl and Dr Peter Tiesenhausen

Co-Sponsors Libby Colquhoun from Urolift with Kim Caffery from Meda