

SCLMA President's Message

Dr Di Minuskin

Over the past month, I have dealt with several situations requiring a great deal of thought and discussion about an event that we all eventually face. The conversation about dying or death is not always an easy one to have. The time restraints of a busy practice, lack of experience or training of the doctor or reluctance on the part of the patient to engage in this topic are just a few barriers encountered. A hastily filled in "Advance Health Directive" produced by the patient at the end of a consultation, when you are already running 45 minutes late does not even remotely address the importance of this subject. Surveys indicate that up to 70% of people would like to die in their own homes, but in reality only about 15% achieve this goal. The remainder are split between aged care facilities 32% and hospitals 54%. The "Baby Boomers" are hurtling toward old age, and the number of people dying each year in Australia is likely to double in the next quarter of a century. This is happening at a time when the number of public hospital beds per capita is decreasing. Why have we come to this point when so many die in hospital, when most have voiced the desire to die at home, surrounded by friends and family?

In the past, death was often precipitous. It was accompanied by rituals and customs that gave the players comfort and an acceptance of death. Dying now, often takes longer. Advances in medical treatments have been able to snatch people away from the jaws of death and delay the inevitable appointment with mortality. However, these advances have also blurred the line beyond which any intervention becomes futile. The answer to the question "am I dying?" becomes more difficult to answer, when on the table in front of us, are a choice of treatments that might snatch another month or two from the grim reaper. Discussions must be had by both the community and the medical profession. This is not a conversation about euthanasia. It is a discussion about the journey and a "good" death. In my experience, patients battling illness who have discussed their wishes for terminal care and with good palliative support, are more likely to report a better quality of life during their last weeks. Their families also seem to experience less anger and depression in the bereavement period. This is also not a conversation about saving money.

Good end of life care is not cheap. But I suspect it might be fairly cost neutral when the expense of community based palliative services are balanced by the freeing up of hospital beds.



We are very fortunate on the Sunshine Coast to have an excellent palliative care service provided by the SCHHS with support from a number of community based palliative nursing services. Facilities such as "Dove Cottage" provide wonderful care. As a GP, providing end of life care is enormously fulfilling. There is readily available advice from the palliative care physicians when needed. Both the patient and family gain comfort from having a trusted family doctor guide them through this journey. On the negative side, it is very poorly remunerated. Note to the Federal Health Minister; the plumber gets paid more for a house call than I do! If we are to offer the large slice of the population about to enter old age a "good" death, we need to plan now for the skills and services needed.

I would like to congratulate the Sunshine Coast Medicare Local on their successful bid to operate the new primary health network. The staff have worked extremely hard to achieve this outcome. Ahead lies the challenge of servicing the huge and diverse area that the new HPN encompasses.

Again, my report is encroaching on my allowed word count. I live in fear of the editor's red pen, or at least the delete button!! Until next month, I wish you all good health.

Di Minuskin

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for the
distribution of
the monthly newsletter.**



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CONTACTS:

President and	Dr Di Minuskin Ph: 5491 2911
Vice President:	Dr Rob Ingham Ph: 5443 3768
Secretary: & AMAQ Councillor	Dr Wayne Herdy Ph: 5476 0111
Treasurer:	Dr Peter Ruscoe Ph: 5446 1466
Newsletter Editor:	Dr Marcel Knesl Ph: 5479 0444
Meetings Convenor:	Dr Scott Masters Ph: 5491 1144
Hospital Liaison:	Dr Jeremy Long Ph: 5470 5651
Committee:	Dr Kirsten Hoyle Dr Denise Ladwig Dr Byron Oram Dr Mason Stevenson Dr Nigel Sommerfeld Dr Jenny Grew Dr Scott Phipps

For general enquiries and all editorial or advertising contributions and costs, please contact:

Jo Bourke (Secretariat)

Ph: 5479 3979

Mob: 0407 037 112

Fax: 5479 3995

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

Please address all correspondence to:

SCLMA PO Box 549 Cotton Tree 4558

Email: jobo@squirrel.com.au

Fax: 5479 3995

Newsletter Editor:

Email: Dr Marcel Knesl

mknesl@oceaniaoncology.com

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MAY 2015

NEWSLETTER

**Deadline Date
will be FRIDAY
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Editor's Column – April 2015

Jeremy Clarkson recently entered very deep and troubled waters.

Punching your programme director may not be the best way to behave especially when you are already 2 strikes down. Topgear that classic car show which pits cars head to head in various locations is facing an interesting future bereft of the classic Clarkson.

From cars to ducks is a very long stretch and a duck challenge would be considered most unusual. But not to be deterred I challenged the classic French dish "Duck a l'orange", roasted duck served with an orange sauce with our own Aussie "Beer Can BBQ Duck", (beer infused).

This recipe I must admit comes from the Luv-a-Duck recipe website and was a great hit with my family over Easter as a slightly unusual Easter Sunday family lunch.

Quick steps: Marinade for the duck includes, 2 tbsp. BBQ seasoning; 2 tbsp. cider vinegar; ½ cup BBQ sauce; ¼ cup maple syrup and 1 tbsp. olive oil.

Rub the marinade over the duck inside and out and allow marinating for at least 1 hour or up to 24 hours.

Remove the duck from the marinade, open a can of XXXX dark and place the can open side up into the cavity of the duck.

Stand the duck upright on a roasting tray so that it balances on the beer can.

Cook on a BBQ with the lid closed for 40 minutes / kg of duck at 180C.



Once cooked remove the duck from the BBQ (careful the beer can is hot) and allow the duck to rest for 15 minutes before carving up and serving with a potato salad and coleslaw.

I will let the photos included in this column do the talking. Frenchies beware!

Moving to a far more serious matter I ask you all to read this month's Presidents report. Death and Dying are tough topics to address with our patients. General Practitioners are pivotal in this role. They have often known the patient over many years; understand the family dynamics and are trusted by the family members.

As Specialists we have a role to communicate very clearly to our General Practice colleagues expected patient outcomes and probable prognosis.

As Oncologists we need to clearly identify to the patient the difference between curative versus palliative treatments. Expected palliative outcomes sometimes come down to a matter of weeks or months and very clear thought needs to be given to the expectations of the patient and family members.

Advanced health directives are a crucial part of palliative care and should be in place once the course for palliative treatment is set. These are emotional times but never underestimate the knowledge and understanding of the patient. They are in charge, we as health professionals are simply there to hold their hand.

So on a happy note, get out there and cook that duck.

Regards,

Marcel Knesl

mknesl@oceaniaoncology.com

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

THURSDAY 28 MAY 2015

Speaker: Dr. Jon Steinberg
Topic: 'CPC Psychiatry Update'
Speaker: Dr Marion Drennan
Topic: 'ECT'
Sponsor: Caloundra Private Clinic
Venue: Maroochydore Surf Club

THURSDAY 25 JUNE 2015

Speaker: Dr. Stuart Collins. Urologist
Topic: 'The new 'Urolift' procedure'
Sponsor: Neotract (David Baker)
Venue: TBA

ENQUIRIES:

Jo Bourke
Ph: 5479 3979 (M) 0407 037 112
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HEALTH SERVICE LINK

April 2015



It is approximately 19 months to the new Sunshine Coast Public University Hospital (SCPUH) at the Kawana Health Precinct opens.

Designed as a 738-bed tertiary hospital, procured through a Public Private Partnership (PPP) the facility will provide the Sunshine Coast Hospital and Health Service (SCHHS) with the capacity to meet projected demand for health services into the future and will see tertiary level services developed and provided.

When the SCPUH is commissioned in November 2016 it will utilise about 450 beds.

The development of a new greenfield hospital of this magnitude affords us with a unique opportunity and responsibility to transform the way services are delivered to our community. We will underpin our approach to meeting this challenge through a model of care process designed to identify and document how services will be reconfigured and redesigned across the SCHHS, including the new hospital. To be completed by July 2015, the process includes a series of workshops and focus groups where clinical and non-clinical staff are actively engaged to develop innovative models of service delivery and evidenced based models of care at SCPUH with expected focus on quality and safety.

Mapping patient journeys across general practice, primary care, acute, subacute and community services will be completed for clinical streams to identify opportunities for greater collaboration to enhance the patient experience and improve admission and discharge interface between services.

A profile detailing how each service unit will function and operate at SCPUH inclusive of staffing requirements, ICT and equipment needs and policy and procedures will also be prepared. The service descriptions and models of care will become foundation documents to inform the progression of service commissioning and transition to the new hospital.

The opening day of SCPUH I am certain will always be remembered as a significant date in the development of our health services; however it will mark a key point in a journey that has no final destination. The focus on the challenge to grow and improve health care in our region will continue.

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 Shaun Rudd



Dear members,

As you may have seen in the media, AMA Queensland recently expanded our *Lighten Your Load* campaign targeting obesity in rural Queensland. As a GP, I'm often taken aback by the number of patients who are overweight or obese, but I am most disturbed when I see young children whose parents are unaware that their child's weight is a problem.

Stage 2 of the *Lighten Your Load* campaign was targeted towards teaching children and their parents about healthy eating habits and the importance of exercise. Rolled out in Hervey Bay, Cairns, Townsville, Mackay and Rockhampton, we were able to visit a range of schools and athletic clubs and speak directly with children and their parents.

The message of this phase of *Lighten Your Load* isn't about encouraging children to diet; rather it's about encouraging healthy swaps such as carrots instead of chips or water instead of juice as well as regular exercise.

The campaign was picked up by local media outlets at each of the regions we visited, allowing us to further deliver this message, get people thinking about their health, and teach kids healthy habits early so we can raise healthy adults.

Beyond the *Lighten Your Load* campaign, children's health has been in the media following the announcement that the Abbot Government will introduce a 'no jab, no pay plan.' Under the plan, parents who choose not to vaccinate their children will lose access to welfare benefits.

It's a hardline approach but, with a conscientious objector rate that has doubled in the last ten years, a hardline approach is needed. I'm glad to see measures implemented that seek to boost immunisation rates, though this must be part of a multifaceted approach that continues to educate the public about the importance of immunisation.

Immunisation has long been a priority of AMA Queensland and is a key area of focus in our *Health Vision*, the first chapter of which will have been released by the time you get this newsletter.

The *Health Vision* is our five year blueprint for advocacy that was developed in consultation with members. At the heart of it are partnerships with Government, local communities and key stakeholders to work towards better health outcomes for Queenslanders.

The *Health Vision* will benefit medical practitioners and patients as it works towards long-term goals to improve the healthcare across the state.

Keep an eye out for the next four chapters of the *Health Vision* which we will start to see released in the coming months.

If you have any questions or would like to contribute to AMA Queensland's advocacy, I encourage you to contact our membership team on 07 3872 2222 or membership@amaq.com.au.

Sincerely

Dr Shaun Rudd

AMA Queensland President

WAYNE HERDY

AMAQ Councillor

ANZAC DAY

Every Anzac Day, I pin a few puny medals to my shirt and field a few questions through the day about what I did and where I went to earn them. I don't wear them to show the world my own military history. I wear them to show the world my respect for all those who went before me. I am conscious that I have only a few insignificant scraps of metal to show my contribution, but I am grateful that they are so few. My personal contribution to world peace is truly quite insignificant compared to the contribution of those who did go before me.

In April every year, we pay our formal respects to the sons of farmers and city larrikins who, exactly one hundred years ago, were carried by steamboat via their final training camps in Egypt to the brutal hills of Gallipoli peninsula. Lest we forget, we echo.

But we pay less attention to the sons of Turkey, a country that lost three times as many as Australia did, defending their land from our invasion.

Every year I remind my audience of how I see the true significance of the Anzac legend. It was the first time that a recently-formed Commonwealth of Australia fielded troops who were Australians, not Victorians or Queenslanders or New South Welshmen. And in the same breath I remind my audience that just as this horrific crucible became the forge for a fledgling Australian nation to appear on the world stage, it was equally a nation-building experience for Turkey, which threw off the last of the yoke of the Ottoman rulers. We always talk of mateship and sacrifice around the Anzac spirit, but this was the moment when Australia was truly born.

The other lesson that we are uncomfortably reminded of is reflected in the words of a song, The Green Fields of France : "Did they really expect that this war would end wars? For, young Willy McBride, it all happened again, and again and again and again and again."

A week before Anzac Day, my own Brisbane-based unit, the 7th Brigade, sent hundreds of our country's young finest into harm's way. In Vietnam, we learned how to deal with what has become the modern form of warfare, one without a traditional front.

And now a new kind of war is evolving, the war dictated by lone-wolf terrorists who will surface, anywhere anytime, inspired by extremists on the other side of the world and transformed by words carried over the internet.

Every Anzac Day, I am forced to reflect on the words of a greater mind than my own: "We have wars so that we can have peace." Some time, maybe mankind will evolve to the level of true civilization envisaged by Mahatma Gandhi and John Lennon, a world where peace can exist and endure without the threat of potential war as a necessary deterrent, a world in which peace can survive by its own power.

A TRIUMPH OF SCIENCE OVER STUPIDITY.

Break out the Bollinger. Prepare the fattened calf. Whatever it is that you do within your culture to celebrate, the time has come. In a rare moment of political strength, we are seeing a government give precedence to science over wanton ignorance.

I am of course referring to the decision to put some real pressure on the anti-vaxxers, testing the reality of their conscientious objections by removing dollars from government handouts if parents persist in refusing to immunize their children.

The overall immunization rate is still only around 95%, not enough to produce herd immunity for the more infectious diseases such as measles. Maybe 1.3% of children remain unvaccinated because of claims of conscientious objection, a figure that has doubled in less than a decade. Can it be true that mass ignorance is increasing in a world that enjoys unprecedented access to an information smorgasbord?

The rest of the unvaccinated are presumably mere oversights, parents who are just too slack. In a world where parents have lots of time pressures to do everything for their kids, school concerts and swimming carnivals take precedence over the unpleasant world of mass immunization. Those parents now face a \$10,000 incentive to get every box ticked. [As an aside, as a boomer whose children left the nest cold a long time ago, I was astounded at the size of the public largesse that is attracted by the patter of little feet.]

WAYNE HERDY

AMAA Councillor

I hold out real hope that this strategy will pick up all those stragglers who just haven't found the time to do the absolute best for their kids.

And what of the 1.3% of supposedly genuine conscientious objectors? I suspect that we will watch that figure fall again over the next decade to a number that reflects the real percentage of our population that will never believe reality, along with those who cling to the flat earth theory and fervently believe that homo sapiens walked alongside dinosaurs.

And what will be the harsh realities at the ballot box? The conscientious objectors will object very loudly, as vocal minorities do. I firmly believe that if this government loses 1.3% of votes at the next election, it will gain nearly that number from parents and grandparents who are grateful to a government that had the guts to protect the little lives that we hold most precious.

It does no good when I read headlines that claim that the medical profession is split on this not-too-subtle coercion.

As a profession, we should be making it as easy as possible for the government to stand firm on this policy, which is even accepted by the Opposition. We should not be giving the ant-vaxxers the tiniest crevice in our armour.



Australia has the second-highest life expectancy in the world, with each successive generation living a few years longer than their parents. This is not because of antibiotics or statins. It is because of effective public health policies put into place by generations of family physicians (OK, let's acknowledge the engineers who gave us clean water and effective sanitation). Immunization has been the biggest single contributor. We owe this much to the memory of Edward Jenner.

As always, the opinions expressed herein are those of your correspondent,
Wayne HERDY



Response from Noeline Ferguson

Wayne, this is an excellent article and I agree with everything you wrote.



I have always believed in vaccination, sadly though there was not much available when I was a child, but my three and the grandies got everything that was available. I will always remember nearly losing Tori because of parents at day care not vaccinating. She was about two, fully vaxxed, a chronic asthmatic and caught whooping cough from an unvaxxed child. If they could have seen this tiny little girl coughing and not being able to breathe they may have realised the importance of it. She was in hospital for days. But why I am I describing this to you, who has seen far worse.

I remember too the terrible callipers polio sufferers had to wear, usually for the whole of their lives, and the horror of the Iron Lung. Another dreadful disease that the younger parents would not have seen, nor even known about.

So, my congratulations to the members of the AMAA for supporting our Government for their stand on the problem. And congratulations to you for an excellent column.

Noeline.



April 2015

SCHHS GPLO news.

Easter has been and gone and we are marching resolutely towards the end of another financial year.

Congratulations to SCML for their successful tender to administer the PHN from July 1st –additional details are to be found elsewhere in this months' newsletter.

This month I would like to provide a further brief update on referrals management here in SCHHS and elsewhere in Queensland. As many of my general practice colleagues know, over the past several months the pre-referral guidelines have been updated

(<http://www.health.qld.gov.au/sunshinecoast/html/services/refer-home.asp#0>).

There has also been a change to the process of incoming referral management to reduce the risk of patients being incorrectly triaged. When further information is requested if this could be supplied with a copy of the original referral it will help ensure all the correct information reaches the triaging clinician. As you can appreciate with several hundred referrals being received each day at the referrals centre, it is difficult to match additional information to referral letters when the information arrives at a separate time. Perhaps you will have noticed some of the care pathways which have been added for common orthopaedic conditions. (See the pathway for OA Knee in Russel Bourne's column). These pathways have been developed by GPs and specialists working locally, with reference to best practice guidelines. Over the next several months there will be pathways published for common Neurological, Urological, Gynaecological and Dermatological conditions. GPs with an interest in participating in this process are encouraged to make contact with either myself (sandra.peters@health.qld.gov.au) or our colleagues at the Medicare Local (zbourne@scml.org.au or jharper@scml.org.au)

At the State level the Clinical Prioritisation Criteria encompassing referral guidelines, triage guidelines and triage to procedure guidelines are progressing, with most of the clinical advisory groups fully convened and working to ensure the guidelines will be ready for implementation by July 1st 2015. The first ten specialty areas to be completed will be Urology, Orthopaedics, ENT, Gastroenterology, Gynaecology, Plastics and Reconstructive Surgery, General Surgery, Neurology, Ophthalmology and Neurosurgery. The SCHHS (in particular the Referrals and Outpatients staff, and myself, as Minister for Complaints!) appreciate the patience and willing attitude to embrace change our local GPs have exhibited over the past several months and we will endeavour to minimise any further changes in this referrals arena. The CPC guidelines will share many commonalities with our existing local guidelines and any differences will be incorporated into the A-Z pre-referral pages with (hopefully) the minimum of disruption.

Last but not least from me this month, there is an exciting new initiative being piloted for men with prostate cancer here at the Sunshine Coast through the TrueNTH project (administered by the charitable organisation Movember) . The pilot project which will run over the next 6-9 months at two sites (here and Northern NSW) will be commencing on May 11th 2015. Initially 40 men will be recruited for each site, and the model of care to be trialled will be integrated into the current local health system. Those GPs who have patients involved in the recruitment process will be contacted by the TrueNTH care co-ordinator, to ensure they are fully informed and remain involved in the management plan for the individual patient. Following evaluation of the pilot in 2016 it is anticipated there will be a larger recruitment/demonstration phase to proceed over the following twelve months. It is envisaged more of the local GP population will have patients who are enrolled in the study at this time. For further information contact Cyril Dixon. (MOBILE +61 418 805 900 EMAIL cyril.dixon@movember.com)

Best wishes,
Sandra Peters

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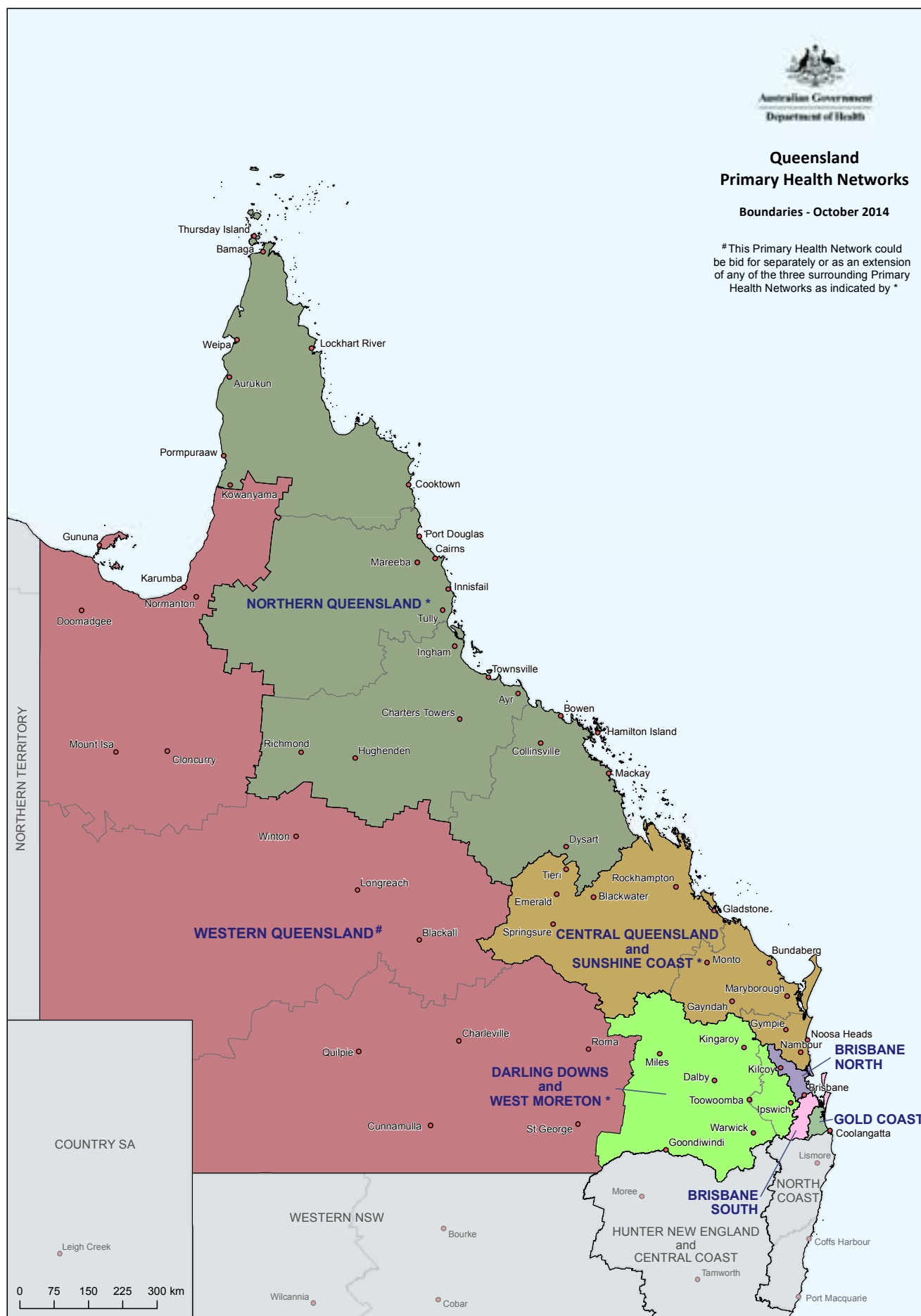

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Queensland Primary Health Networks

Boundaries - October 2014

#This Primary Health Network could be bid for separately or as an extension of any of the three surrounding Primary Health Networks as indicated by *



SUNSHINE COAST MEDICARE LOCAL UPDATE

Patti Hudson

Sunshine Coast Health Network Ltd (SCHN), the entity that trades as Sunshine Coast Medicare Local, is delighted to finally announce it has been successful in its bid to operate the Central Queensland and Sunshine Coast Primary Health Network (CQSCPHN) to coordinate primary health care services for the Central Queensland, Wide Bay and Sunshine Coast regions.

One of our highest priorities is to work closely with GPs in the Wide Bay and Central Queensland regions – whilst continuing to work with GPs in our existing Sunshine Coast and Gympie region - to ensure that services across the expanded region meet the needs of the community. This open communication with health providers and service delivery organisations, as well as the existing Medicare Locals in Wide Bay and Central Queensland will facilitate a smooth transition into the launch of the CQSCPHN on 1 July 2015.

We look forward to listening to GPs across the region, and engaging formally with health practitioners. The Clinical Councils will be established to provide recommendations and advice to the Board of the Primary Health Network and Hospital and Health services. The government has set six key priorities for the Primary Health Networks – mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

CQSCPHN will be the knowledge leader in health services for the region, maintaining a strong local presence in all corners of the region. Through robust population health planning we will identify where there are gaps in primary health care, and commission local providers to provide effective services. This evidence-base will also provide a thorough understanding of the health priorities of the broader region, as well as identifying key health issues in sub-regions and smaller population groups across Central Queensland, Wide Bay and Sunshine Coast.

In the last three years operating Sunshine Coast Medicare Local, we have established a strong track record of working with GPs, our Hospital and Health Service, local Councils, community groups and other stakeholders to implement innovative health solutions for the Sunshine Coast and Gympie regions. Under the new Primary Health Network, we will continue to build and enhance upon the improvements made under the Medicare Local.

We look forward to working with the existing Wide Bay and Central Queensland Medicare Locals and their communities to build on existing innovations and enhanced services in the communities.

Meanwhile, it's business as usual here at Sunshine Coast Medicare Local. We have been fortunate to maintain almost all our staff, despite the uncertainty around the future. Our programs are funded to 30 June 2015 and we will keep delivering the same high quality support and coordination to the region up until that date, alongside the work we are doing for the transition.

We are pleased to introduce our consortium partner in the Sunshine Coast and Central Queensland Primary Health Network; Abt JTA, an international and national health and social organisation, specialising population health planning and the development and implementation of primary health care services to meet the needs of discrete communities.

We have an alliance with Philips Healthcare, a global healthcare brand at the cutting edge of health, diagnostic and communications technologies; and Westfund, a local member-owned private health insurer with a commitment to regional communities. This will strengthen our ability to provide innovative and efficient services as part of the Primary Health Network.

Evidence suggests that countries with a strong primary care sector have better health outcomes for individuals and their communities. This is an amazing opportunity to build on the strong foundations of primary health care for the region. We look forward to this opportunity to re-energise the health services environment for the benefit of the people we serve and to ensure that primary and preventive health is prioritised in our region.

We are fortunate that the region has a vast range of local skill and talent in health service delivery, and communities with strong ideas on improved and we look forward to sharing in that knowledge to benefit the community and maintain service continuity.

We value the input of health professionals across the region, and while we will be undertaking formal consultation, we are happy to hear from our stakeholders at any time.

Please follow the Primary Health Network link under About Us on our website at www.scml.org.au

Pattie Hudson CEO



Sunshine Coast Orthopaedic Clinic

The Acute Knee Clinic

The first few days can make all the difference in recovery from a sporting injury.

Dr Steve Lawrie at the Sunshine Coast Orthopaedic Clinic provides an Acute Knee Clinic each Monday and Tuesday which is specifically designed for, but not limited to, sports injuries of the knee with a view to rapid assessment, investigation and adoption of a management plan within the first few days of the initial injury.

The Acute Knee Clinic has now been running for eight years. We have treated many professional and semi-professional athletes as well as the "weekend warriors", including a special interest in paediatric sporting injuries. Dr Lawrie has a close association with many sporting teams on the Sunshine Coast, including the Sunshine Coast Sea Eagles and the Sunshine Coast Stingrays.

Individual treatment plans are developed for each patient encompassing pre-operative care, surgery and non-operative treatment and a post operative plan leading up to and including a return to sport assessment.

Dr Lawrie works hand in hand with the patient's physiotherapist, coaching staff etc as needed to get the best possible outcome. Communication with allied health professionals is the key in this regard.

Specific conditions that can benefit from emergent assessment include suspected ligamentous injuries, including cruciate ligaments, medial ligaments, multiple ligament injuries, acute patellar dislocation, locked knees and especially paediatric cruciate and meniscal injuries whether that be by implementing early surgical techniques or an appropriate non-operative treatment programme. Some examples of these injuries include:

- ❖ A medial ligament injury is usually easily treated in a range of motion brace, using an MCL protocol if applied within the 1st week or so. But it can be extremely difficult to correct if there is a delay of a number of weeks.
- ❖ Paediatric meniscal tears may be repairable early after an injury, but a delay typically means meniscal resection becomes necessary.

For appointments contact

Dr Steven Lawrie
Suite 17, Kawana Private Hospital
5 Innovation Parkway, Birtinya QLD 4575
p: 07 5493 3994
f: 07 5493 3897
e: info@sunshineortho.com.au
www.sunshineortho.com.au

- ❖ Acute patellar dislocation may respond to surgical repair if surgery is offered in the first 2 weeks after the injury.
- ❖ Early ACL surgery in the young active patient/sportsman.

To access the Acute Knee Clinic, a patient needs to have a current referral to Dr Steven Lawrie and plain x-rays of the knee should also be arranged before the initial consultation.

A plain x-ray is very important in the initial assessment to exclude fractures, loose bodies, and to show the alignment of the knee joint and the patellofemoral joint, which cannot be seen on other investigations, such as an MRI scan.

Splints and orthotics can be organized directly with Leonie Walton on 5473 5858. Leonie attends our clinic on a Thursday afternoon, but she is available throughout the week as needed.

The Acute Knee Clinic is intended to complement Dr Lawrie's other interests, including hip and knee replacement, revision arthroplasty, computer assisted joint replacement, cartilage surgery, as well as hip, knee and ankle arthroscopy.



Dr Janusz Bonkowski

NEUROSURGEON & SPINAL SURGEON

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- Degenerative disorders of the spine
- Microsurgical techniques in the management of spinal pathology
- Anterior foramenotomy in cervical disc disease



Dr Terry Coyne

NEUROSURGEON & SPINAL SURGEON

Dr Coyne visits SCUPH monthly and specialises in:

- Cerebrovascular surgery
- Skull base surgery
- Spinal surgery
- Movement disorder surgery

Consulting at:

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Birtinya QLD 4575

Noosa Hospital

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Knee Pain

Assessment	History	Examination
<p>Red Flags</p> <ul style="list-style-type: none"> ☞ Suspected septic arthritis (e.g. red skin, fever, systemically unwell) - call (07) 5470 6600 and ask for Orthopaedic Registrar ☞ If suspicion of acute significant internal derangement, refer to Fracture Clinic ☞ Pain in previously well-functioning arthroplasty 	<p>Date and mechanism of injury or evolution and duration of symptoms</p> <p>True locking (vs intermittent stiffness)</p> <p>Pain and other symptoms including swelling, locking, instability</p> <p>Impact on patient's activities of daily living, mobility and employment</p> <p>Past joint surgery and surgeon if known</p>	<p>Ligament and meniscus testing</p> <p>BMI and waist circumference</p> <p>Hip and Knee Questionnaire</p>
↓		
Investigations	Imaging	Pathology
	<p>Plain X-Ray: Weight bearing AP of both knees for arthritis)</p> <p>MRI (acute injury)</p>	<p>FBC, ESR, CRP (if inflammation suspected)</p>
↓		
Treatment: Primary/Secondary	Physical	Pharmacological
<p>Undertake multimodal therapies</p> <p><i>GP to provide information</i></p>	<p>Activity modification</p> <p><i>GP to provide information</i></p> <p>Physiotherapy under GPMP/TCA (721/723) as per AH protocol</p>	<p>Paracetamol</p> <p>Use NSAIDs with caution to side-effects</p>
↓		
Treatment: Tertiary	Referral to Orthopaedic Surgeon/Service	
<p>Referral eligibility:</p> <ul style="list-style-type: none"> • All treatments have been undertaken and symptoms persist • Patient ready for surgery 	<p>Referral must include:</p> <ul style="list-style-type: none"> • Consultation notes • Physiotherapy reports • Imaging reports • USS-guided injection reports • Hip and Knee Questionnaire <p>NB: Incomplete referrals to SCHHS, under this Pathway, will be automatically returned for completion and resubmission</p>	

If you feel any patient needs clinical review or falls outside of these guidelines please contact the registrar on call for advice on (07) 5470 6600.



SUNSHINE COAST

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– Montserrat Cancer Care –



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Dr John Reardon
Medical Oncologist / Clinical Haematologist

Dr Hong Shue
Medical Oncologist

Dr Sorab Shavaksha
Clinical Haematologist

Dr Rosanne Middleton
Clinical Psychologist

Tania Shaw
Oncology Massage Therapist

Sarah Higgins
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for further information ...

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web : www.schoc.com

email : reception@schoc.com

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Caloundra Private Clinic New Mental Health Day Programs

Caloundra Private Clinic has a successful history of helping people with anxiety & depression & is proud to announce a **BRAND NEW** Cognitive Behavioural Therapy (CBT) Day Program to assist your patients. The outpatient course will be held every Tuesday from 8.45am until 3.00pm at our new Day Program area at the clinic.

It is an "open" 16 Week Program offering outpatient treatment & an ongoing support group for people who experience problems with anxiety & depression.

What is the program about?

- Anxiety management
- Depression management
- Relationships
- Relaxation training
- Managing emotions
- Challenging negative thinking
- Stress management
- Communication training
- Activity scheduling
- Relapse management



A written referral from a Psychiatrist or General Practitioners is required for attendance to the program.

Should you wish to discuss the program further, please contact our Program Coordinator - Clinical Psychologist, Lesleyanne Mason on 07 5491 1522

www.caloundraprivateclinic.com.au

CALOUNDRA PRIVATE
CLINIC

96 Beerburum St, Caloundra QLD 4551 **Ph: 07 5491 1522**

INTRODUCING DR CHARIS GAUVIN

Dr Charis Gauvin is a fellow to the Royal Australia and New Zealand College of Psychiatrists (RANZCP), with dual advanced certificates in Child & Adolescent psychiatry as well as psychotherapy and is a member of both faculties. She has worked in urban and rural South Australia, Queensland, Victoria and New South Wales with children, adolescents and adults in both inpatient and community settings.

Dr Gauvin has a strong interest in working holistically with young people and their families to best support them in addressing any mental health concerns.

With a long-standing interest in psychotherapy she is a keen advocate of working systemically with young people around their needs, as well as utilising biological interventions where appropriate.

Due to her broad range of clinical interests, Dr Gauvin has also undertaken additional studies in Family therapy, infant mental health and Parallel Parent Child Narrative. Her focus is on assessment and treatment and she does not see patients for the purpose of providing medico-legal reports. She plans to stay permanently on the Sunshine Coast and to work with young people and their families in the local community.



Contact Details:

Caloundra Private Clinic
96 Beerburum Street
Caloundra 4551

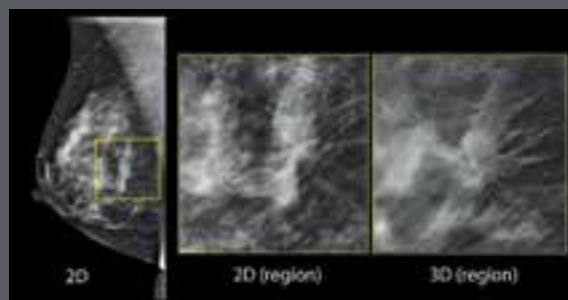
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Neuro Physiotherapist, Laura Perry has extensive experience in assisting people with Stroke, Parkinson's disease & other movement disorders, Acquired brain injuries, Spinal cord injury, Post-hospital rehabilitation, Transition Care, Community Support & Rehabilitation Team, High falls risk and progressive neurological conditions.



Laura Perry has a special interest in the treatment of clients with disorders of movement, posture and function that arise from impairments of the body's nervous and neuromuscular systems. These conditions often manifest themselves in loss of mobility function and muscle weakness, poor coordination, sensation loss, uncontrolled muscle activity such as spasticity and tremors, and loss of balance, or orientation.

Laura works on re-education of key functions including walking, standing and use of the hands and arms for every day tasks. Laura is also able to assist individuals wishing to progress to work related tasks, sporting and recreational interests including running retraining.

Laura is based in the Maroochydore Practice

For more information visit us online, call Maroochydore on: 5479 1777
Or, email Laura directly: Laura@sportsandspinalphysio.com.au



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Caloundra	5437 2679
Coolum	5351 1733
Kawana	5438 8511
Nambour	5441 2744
Chermside	3833 2555
Sippy Downs	5373 0070

Deceased Estates & Taxation – it is important!



Taxation and deceased estates is a topic not a lot of us like to think about. No one likes talking about Wills and dying. Increasingly I hear stories from clients about the lack of planning with Wills and Estates. It is quite a bizarre scenario, people work all of their lives to accumulate wealth, through planning & strategies, but don't make any plans to protect this wealth upon death. One craziest sentences I hear is "I'll be dead so I don't care".

I am an accountant and work in the taxation of deceased estates. Once someone is dead they can't tell you any answers or show you where paperwork is. So what am I trying to say?

Firstly – how good is your recordkeeping? For tax purposes your records are probably quite sufficient but what about Real Estate documents of ownership including contracts/quantity surveyor reports.

Share contracts

Bank Accounts

Insurance documents – Life/ Trauma/Income Protection/Motor Vehicle /House.

Superannuation & Binding Death Nominations

Other financial documents

Check out www.kickthebucketlist.com a secure online storage website for these documents.

Secondly seek out your solicitor and your accountant and talk about your Estate. Work out what is going to work best for your family. By having both professionals in the room you should be able to work out the best result to maintain your family wealth. We have done this quite a few times and it has given great results.

Thirdly actually complete the Will process and sign off on it. Another scenario too often repeated is the Will is completed, but never signed off.

Fourthly, talk to your Executor and tell them everything. If any of you have ever been in the position as an executor I'm sure you can understand the frustration & difficulty this role presents. The 2 largest issues we see are conflict within the family and inability to find documents.

Fifthly, talk to your family and make your wishes known not only on the financial side of things but also for all the sentimental heirloom items. Discuss with the solicitor if there are options to specify these items in your Will.

We are very happy to assist anyone with Deceased Estate Taxation questions and preparations of Deceased Estate Returns. Quite often we assist solicitors & executors with their questions/ concerns in the finalization of estate matters for tax. It isn't always an easy process as lack of or missing documentation is generally an issue. We can assist with Superannuation & Insurance recovery and finalization, Final Deceased Estate returns and Off Market Transfers of Shares.

The one thing in life that is certain is death. It's just a fact.

The way I look at it is prepare now and then its done. Revisit your wishes occasionally but live your life with knowledge that your legacy is protected.

After recently experiencing a death in the family it only serves to make me more passionate not to see other families experience the same frustration on top of grief as I have personally felt and professionally witnessed.

Next month I will detail a case study to highlight some Deceased Estate Taxation issues specifically targeting scenarios common to most Medical Practitioners including Trust/Company and Self Managed Superannuation Funds.

I would be happy to help anyone out with questions raised from this article so please call me on 5437 9900 or drop me an email Kwelsh@poolegroup.com.au.

Cheers

Kerri Welsh



New Specialist Joins the Fertility Solutions Team

Fertility Solutions would like to welcome Dr. Nerida Flannery. Nerida is an obstetrician, gynaecologist and fertility specialist practising exclusively at The Sunshine Coast Private Hospital in Buderim.

Nerida is a fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and was awarded a Masters of Reproductive Medicine from the University of New South Wales in 2015. She has a special fertility interest in recurrent miscarriage and implantation failure.

Prior to setting up her private practice, Nerida worked as a Senior Registrar in Obstetrics and Gynaecology (O&G) at Redcliffe Hospital, following similar senior O&G roles at The Sunshine Coast Private Hospital and Nambour General Hospital. She also spent a year as an O&G registrar at Royal Brisbane and Women's Hospital, where she was able to gain experience in High-risk Obstetric medicine, as well as Urogynaecology, Adolescent Gynaecology and Gynae-oncology.

Nerida brings passion and enthusiasm to her practice. Her experience both as a clinician and a mother of two small children means she is well qualified to offer high quality service and genuine empathy to new families and parents-to-be. Her ability to put her patients at ease through open, clear communication and candid information helps women understand and actively participate in their health and wellbeing.

Nerida has extensive clinical practice with emergency and elective gynaecological surgery and care of inpatient and outpatient obstetric and gynaecological patients.

During the formative years of her career, Nerida decided to specialise in obstetrics and gynaecology. Raised in Mt Isa, she won a Queensland Health Rural Scholarship to assist with her studies and completed her Bachelor of Science and Bachelor of Medicine/Surgery at the University of Queensland in Brisbane in 2002. A strong interest in infertility and reproductive medicine led to her pursuing and attaining her Masters Degree in recent years.

Nerida has lived, studied and worked on the Sunshine Coast over the past decade. She loves her work and is committed to providing high quality and empathic care for all women, and their families, throughout all the phases of life.

Nerida will be practicing out of Suite 22, Building B, Nucleus Medical Suites, Elsa Wilson Drive, Buderim. Appointments can be made from 20th April 2015 by phoning 07 5452 5415.

Nerida also plans to consult in Kingaroy in the near future.

For more information visit www.drneridaflannery.com.au

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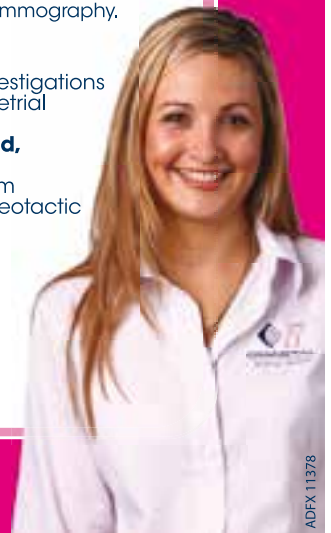
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MEDICAL MOTORING

with Dr Clive Fraser

Mini Cooper S Restoration (Part 3)



After spending so much time, energy and money on the restoration of the Mini Cooper S it's great to see that it's finally on the home stretch.

With the re-built engine installed and running it's now time to add some of the finishing touches.

45 years of UV light and wear and tear can take its toll on all of the window and door rubbers, but fortunately they are all still available for purchase at \$600 for a full set.

The seats have been re-upholstered and the cabin is all back in one piece at last.

So it's finally time to take the Mini back out on the road.

The engine ticks over nicely and with the gearbox completely re-conditioned everything should be as good as new.

But, alas there is a problem.

The gears aren't changing freely and it's necessary to double de-clutch on every change.

That means slightly revving the engine in neutral to try to match the revolutions of the input and output shafts particularly when down-shifting.

How could this be? After all the Mini had a brand new clutch.

Further investigation revealed that the culprit was a worn clutch pedal pivot bush.

The movement in the loose bush meant that even when the clutch pedal was fully depressed, the other end of the shaft just wasn't moving through its full ROM and therefore the clutch was not fully dis-engaging.

Once discovered it was a simple fix for a problem too subtle to spot on the re-build.

So what was the Mini like on the road? Well frankly, just a little disappointing!

It is after all a 45 year old design which lacks all of the modern engineering that makes 2015 cars feel so refined and smooth.

There's no power steering, no air conditioning and the performance is sluggish compared to a modern turbo-powered car.

In the event of an emergency there is no ABS, no airbags or crumple zones and crashing in a Mini was never meant to be injury free.

So for a total investment which could have bought a fairly new hot hatch was the whole job worthwhile?

Well yes, I think so.

Because restoring the Mini was never about making a profit.

It was about restoring a piece of motoring history and bringing the little car back to its full glory, just like it was when it left the factory.

Would my friend tackle the whole job again?

He'd have to think about that.

PS. Once completed my friend reluctantly decided to sell the Mini.

It didn't last long on carsales.com.au and the new owner really didn't pay a premium for all the time and effort that had gone into the restoration.

He mentioned that he was thinking about changing a few things on the car like installing a stereo system.

Expecting that might happen, my friend advised the new owner that he'd pre-wired the car for whatever stereo he might install, but he also warned the new owner that whatever he did from here that changed the car from its original stock build would de-value it.

Proving the point that it's often better to leave things alone and stick with the original, particularly if it has stood the test of time.

1970 Mini Cooper S

Engine: 1275cc 4 cylinder OHV

Power: 45 kW @ 5550 rpm

Torque: 91 Nm @ 3000 rpm

0-100 km/h in 12 seconds

Top speed 148 km/h

7.3 l/100km

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

Mini Cooper S Restoration (Part 3) /cont:



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The date has been set

Mark your diaries!

SATURDAY 8th AUGUST

*Venue still being decided - possibly
Noosa direction?*

Let us know what you think!



Plantar Fascitis

Clinical history: Pain Heel.

Findings

Thickened plantar fascia (white arrow) with surrounding edema, and edema in the posterior process of the calcaneus.



Diagnosis

Findings in keeping with plantar fasciitis.

Discussion

Plantar fasciitis refers to inflammation of the plantar fascia of the foot. It is considered the most common cause of heel pain.

Clinical Presentation

Pain on the undersurface of the heel on weight bearing is the principal complaint. It can be worse when weight is borne after a period of rest (eg, in the morning) and eases with walking. Passive dorsiflexion of the toes may exacerbates discomfort.

Pathology

It is generally a low-grade inflammatory process involving the plantar aponeurosis with or without involvement of the perifascial structures.

It can arise from several factors

- mechanical - stress of repetitive trauma - more common
- degenerative
- systemic - as an enthesopathy in association with seronegative spondyloarthropathies
 - ankylosing spondylitis
 - Reiter syndrome
 - psoriatic arthritis

Radiographic Features

Plain Film

Plain film features are non specific but may show an associated plantar calcaneal spur although this is also seen in asymptomatic individuals.

Ultrasound

Often the initial imaging modality of choice. Ultrasound typically shows increased thickness of the fascia and a hypoechoic fascia.

MRI

Signal characteristics of affected tissues include

- STIR - very sensitive in the detection of both fascial and perifascial oedema, which appear as poorly marginated areas of high signal intensity
- T2 - high signal
- T1/PD - intermediate signal
- Other MRI features include
 - plantar fascial thickening - often fusiform and typically involves the proximal portion and extends to the calcaneal insertion.
 - increased T2 - STIR signal intensity of the proximal plantar fascia
 - oedema of the adjacent fat pad and underlying soft tissues
 - limited marrow oedema within the medial calcaneal tuberosity may also be seen



Treatment and Prognosis

Management options are usually conservative.

Local injection of Dexamethasone / steroids may be useful to manage symptoms (this can done under ultrasound).

Other supportive measures include weight reduction in obese patients, rest, nonsteroidal antiinflammatory medications and reduction of weight-bearing pressure (soft rubber heel pad, molded orthosis, or heel cup or soft-soled shoes)



WELCOMES ...

Tania Shaw

- Oncology Massage Therapist

Qualified in Oncology Massage and Complex Lymphatic Therapy, Tania is the QLD Coordinator and Facilitator for internationally renowned Oncology Massage Training.

Using advanced rehabilitative techniques, Tania works holistically with range of movement difficulties and other issues that may arise from the treatment of cancer, and provides self-care education to empower and facilitate wellbeing.

Whilst she focuses on those who are living with the physical effects from the treatment for cancer, Tania also offers her massage skills and services to extended family and friends.

Tania operates a **part-time private practice** in **oncology massage** from Sunshine Coast Haematology and Oncology Clinic.

Appointments : Phone 5479 0000

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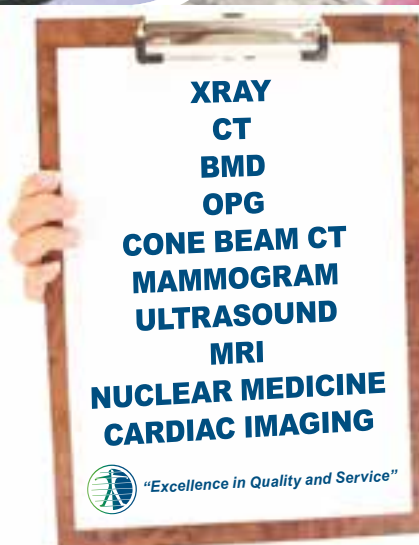


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Pav A, 111 Goodchap St
Ph: 5430 5200



MALIGNED MERLOT



It's hard not to discuss the red grape, Merlot, without touching on the US movie "Sideways". The main character Miles, has several tantrums declaring his disdain for "insipid" Merlot. Ironically, his most precious wine is a 62 Cheval Blanc which is 95% Merlot and 5% Cabernet Franc. The consumption of Merlot decreased as a result of his tirade.

It had a kick along in Australia in the 90's with many female drinkers searching out Merlot as they ventured from Chardonnay into the realm of the red. It makes sense as Merlot can be a silky fruit driven wine with subtle tannins.

But few Australians realize it is the most widely planted grape in France and about 5th in the World. Its Father is Cabernet Franc, adding structure with tannin and anthocyanin and its mother is a wild local grape in France called Magdeline Noir des Cheventes. It seems the Mother always adds the sexy fruit.

Its spiritual home is the right bank of the Gironde River in Bordeaux. Pomerol and St Emilion being powerhouse planters. It is suited to the wetter conditions with the ability to ripen 1-2 weeks prior to the finicky Cabernet Sauvignon it is often blended with. Merlot is renowned for the filling of the "doughnut hole" in Cabernet Sauvignon. It has the potential for high yields and higher alcohol levels. Cabernet Franc, Malbec and Petit Verdot make up the classic "5" Bordeaux blend grapes.

It has found its way across cooler Europe from North East Italy e.g. Friuli, Trentino into Slovenia and Romania etc. In the warmer Tuscan area, it is blended with Sangiovese to make the well sort after "Super Tuscan" reds. Napa and Sonoma and Washington State are well known in the USA. Chile and Argentina grow it well. For many years Carmenere, its Cousin, was thought to be a powerful rich strain of Merlot.

Australian wine growing was drawn into the Merlot revolution with many growers backing its new wave status. It was first planted in 1980, disappeared and was resurrected after 1988. Poor clone selection, poor understanding of growth characteristics and incompetent wine making techniques has seen it fall away from its Cinderella status. The public isn't stupid with their palate.

Adelaide Hills, Coonawarra, Barossa/Eden Valley, Margaret River and Yarra Valley produce great Merlots.

Hats off to the Kiwi cousins. Some of the NZ Merlots are the thinking mans red in the sea of Pinot Noir. The Gimblet Gravels areas of Hawkes bay excel. It is often said that the Merlot is Cabernet without the pain.

Wines tasted

- **2012 Parker Estate Coonawarra Merlot-** A bright red in colour. Nice lively red fruits, hints of plum and herbal notes. The palate is refined with moderate fruit, good structure with a mid-palate finish. This wine evolves over an hour and was great with some roast smoked chicken (skin on with juicy fat). Cellar 4-5y
- **2012 Irvine Song Hill Barossa Merlot-** James Irvine is the king of Merlot. His Grand Merlot is genius in a bottle. The competitively priced merlot tasted has some dark red colours. Aromatic juicy stewed plums integrate with good vanillin notes from the oak. The palate is plush with mid palate integrated tannins. Very nice with Chicken Cacciatore. Cellar 5-7y.
- **2013 Kim Crawford Hakes Bay Merlot-** a very dark purple. The nose is intense with prunes and spicy dates. The aromas are of a foreign nature with brambly mineral overtones. Sharp anterior palate with good acidity but little tannin effect. A good value wine fewer than 20 dollars if you need a NZ fix.
- **2010 Kendall-Jackson Sonoma California-** Intensely purple. Another foreign nose with prunes licorice and earthy tones. Exceptional fruit and massive oak, American and French. Full juicy palate, almost port-like with nicely balanced tannins. One Big Merlot! I really enjoyed this with some 9 plus baked wagyu.

Dr Plonk

KOKODA !!!

Few names can evoke such a range of emotional responses in the hearts of Australians. Courage, sacrifice, mateship, endurance – the proud qualities of the Australian soldier. An immense physical challenge for those who walk the modern Track – as I did last month. Unequalled jungle mountain scenery.

The significance of Kokoda is that it was the first time, and so far the only time in history, that Australian soldiers were defending their homeland, on what was then home turf, against a foreign invader. For a reservist soldier, as I still am, there is also the tradition that the poorly-trained and poorly-equipped soldiers who fought a brave fighting withdrawal against superior numbers of crack experienced and well-equipped Japanese troops, were reservists (until quite late in the campaign).

We also bear forever the shame that our men were commanded by an American general, Douglas Macarthur, who signalled from the safety of his Melbourne headquarters: “the casualty rate does not justify the failure to advance”. Macarthur believed that our engineers should just bulldoze a highway through mountains where, even today, pack mules cannot travel. Our political slavery to America did not teach us a lesson and we were to repeat the mistake in Vietnam three decades later.

How hard was it? I have never done anything so physically difficult – even though I trekked in the relative comfort of the dry season. Nothing in Australia resembles the relentless hills, the unending mud, the heat and humidity, that Kokoda imposes on the visitor.

What pervades the Track? The military history, the confined battle conditions, the innumerable surviving fighting trenches, the memorials at Popondetta, Kokada, Isurava and Brigade Hill, and the hard remnants of an impossible war.

What is my most enduring memory? That the tradition of the Fuzzy Wuzzy Angels is alive and well and in the good hands of their descendants, the porters who make the trek possible for the 4000 Australians (and few non-Aussies) who walk the Track every year.

My walk was my personal tribute to the thousands of kids who died there 70 years ago. I felt a little of their pain, I left a little of myself behind in the place where they left their entire earthly remains. Let us all honour their memory.

Wayne Herdy



Route 66, USA

Route 66 joining Chicago and Los Angeles, once served as the major road corridors of USA. It is considered as a paradise for cruisers, who love to venture out on open roads and experience the classic historical aspect of American history. The road itself plays an important part in native communities and regularly features in songs, movies, and TV shows.

The 2200 miles of long road in western America stretches out to great variety of activities and takes you directly to the soul of American life, through Urban Chicago, spectacular Grand Canyon and the famous Santa Monica beach.



What Route 66 offers you?

Route 66, along the way, offers many attractions and lets you peek into the American countryside life.

- **Museums** – Route 66 is home to Will Rogers Memorial Museum in Claremore, Cadillac Ranch in Amarillo and Georgia O'Keeffe Museum in Santa Fe among several others. At Will Rogers Museum, indulge yourself in collection of art, telling the life story of legendary movie star, Philosopher, Columnist. The Cadillac Ranch features 10 Cadillac in a line, buried nose dip in sand. It was opened in 1974 and remains a popular tourists spot for street art fans. Georgia O'Keeffe Museum is home to more than 4000 art forms created by the renowned artist and a research center pioneering in the study of American Modernist art forms.
- **Paradise for the Food Lovers** – The route is lined up with numerous roadside restaurants, cafes and Bed & Breakfast motels. There are many famous diners, dating back to 1920s when original route 66 was commissioned. Clanton's Café in Arizona, Cozy Dog Drive In, 66 Diner in Albuquerque, Dixie Truckers Home, and Summit Inn in California are some of the oldest cafés on the route offering Native American food, in the original 1930s style.
- **Attractions** - The road trip along pop cultural iconic Route 66 is complemented by the attractions which make the trip even better and interesting. Each stop is unique in its own sense and has helped in keeping the appeal of the trip throughout decades. The major attractions include Chain of Rocks Bridge, Sears Tower, Route 66 Rocking Chair, Painted Desert, The Site of World's First McDonald's and Lowell Observatory.
- **Santa Monica Beach** – Santa Monica beach marks the end of splendid road trip through route 66. The beach is flocked by international tourists and surfing community as well. Santa Monica beach is lined by swaying palms, clear waters, and a lively crowd, complementing the termination of route 66. Take a walk through the beach towards Santa Monica Pier, which declares itself as "End of the Trail".

What we have planned for you?

We have developed a detailed itinerary for your road trip *so that you don't forget to look around and miss exciting attractions*

- Starting the road trip from Chicago with a visit to Sears Tower
- Taking stops along the route at roadside cafes and motels to experience American countryside lifestyle
- A visit to Cadillac Ranch and Rocking Chair of Route 66 to get a picture perfect memory
- *Visit to Santa Monica, ending amazing trip and relaxing at beach in the vicinity of swaying palm trees, enjoying scenic beauty over Pacific Ocean*

Book a journey today across this famous route.

Cheryl Ryan 123Travelconferences

www.123Travelconferences.com.au

Australian Medical Association Limited
ABN 37 008 426 793

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

**MEDICAL GROUPS REMEMBER THE DOCTORS AND OTHER
HEALTH WORKERS WHO SERVED AT GALLIPOLI**

AMA President, A/Prof Brian Owler, will today officiate at a special ceremony at Canakkale, Turkey, to pay tribute to the doctors and other health workers who cared for the injured and dying from all sides at the Gallipoli landing 100 years ago.

The Turkish Medical Association invited representatives from the Australian Medical Association (AMA), New Zealand Medical Association (NZMA), and the World Medical Association (WMA) to commemorate Gallipoli, honour the ANZAC spirit, and send a strong message of peace and friendship.

A/Prof Owler and NZMA Chair, Dr Mark Peterson, are representing the ANZAC nations, and will make presentations on the important role of doctors in the conflict.

A/Prof Owler said Gallipoli was a significant event in our history, and there were great sacrifices made on all sides.

“Doctors and nurses provided vital care for the wounded and dying in terrible conditions,” A/Prof Owler said.

“It was before antibiotics and many of the medical resources that we take for granted today.

“Casualties were heavy right from the start. In the first four days of the campaign, 3300 wounded passed through the 1st Australian Casualty Clearing Station.

“In the first five weeks of the campaign, more than 20,000 wounded were taken to Alexandria.

“By the end of the campaign, Australian fatalities totalled 8709, and more than 19,000 were injured.

“There were 2,779 New Zealand fatalities, and 5,212 injured.

“The fact that many with horrific injuries survived is testament to the bravery and dedication of the doctors and nurses who provided care at Gallipoli.

“As we remember the soldiers who made the ultimate sacrifice and those who survived, it is fitting that we honour the efforts of the health workers who also served with distinction,” A/Prof Owler said.

24 April 2015

CONTACT: John Flannery 02 6270 5477 / 0419 494 761
Odette Visser 02 6270 5412 / 0427 209 753

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COORDINATED NATIONAL ACTION NEEDED TO CLOSE THE GAP *Close the Gap Day 2015*

AMA President, A/Prof Brian Owler, said today that coordinated national action from all governments and the health sector, including the medical profession, is needed to restore momentum to efforts to close the gap in health and life expectancy between Aboriginal and Torres Strait Islanders and other Australians.

A/Prof Owler said that last month's *Close the Gap Campaign Report* and *Prime Minister's Closing the Gap Report* showed that targets for life expectancy, reduced mortality rates, and other key performance indicators are not being met or are not on track.

"Despite modest gains in some areas for Aboriginal and Torres Strait Islander people in recent years, progress is slow and much more needs to be done," A/Prof Owler said.

"Smoking rates are going down slowly, and we're on track to halve the rate of mortality for children under five years of age by 2018.

"This is encouraging, but we still have a life expectancy gap of around ten years between Aboriginal and Torres Strait Islander people and other Australians. And the death rate for Aboriginal and Torres Strait Islander children is still more than double the rate for non-Indigenous children.

"This is simply unacceptable in the 21st Century. We can, and must, do better," A/Prof Owler said.

A/Prof Owler said that recent data have identified stubbornly high levels of treatable and preventable conditions, high levels of chronic conditions at comparatively young ages, high levels of undetected and untreated chronic conditions, and higher rates of co-morbidity in chronic disease.

"A higher prevalence of risk factors for chronic disease – mental health conditions, smoking, overweight and obesity, and harmful drinking levels – also persistently contributes to poor health outcomes for Aboriginal and Torres Strait Islander people.

"In the face of this unacceptable disparity, the AMA remains committed to working in partnership with Aboriginal and Torres Strait Islander groups to advocate for greater Government investment and cohesive and coordinated strategies to improve health outcomes for Indigenous people," A/Prof Owler said.

The AMA works closely with groups such as the National Aboriginal Community Controlled Health Organisations (NACCHO) and the Australian Indigenous Doctors' Association to ensure a network of adequately remunerated, sustainable and responsive primary health care services and a strong Aboriginal and Torres Strait Islander health workforce.

19 March 2015

CONTACT: John Flannery 02 6270 5477 / 0419 494 761
 Odette Visser 02 6270 5412 / 0427 209 753

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

<u>NAME</u>	Surname:		First Name:	
EMAIL:				
<u>PRACTICE ADDRESS:</u> 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:	
<u>ALTERNATE ADDRESS:</u> (if practice address not applicable)				
	Street:			
	Suburb:		Postcode:	
	Phone:			
<u>PRACTITIONER DETAILS:</u>				
	Qualifications:			
	Date of Birth:		Year of Graduation:	
	Hospital employed / Private Practice (cross out one)			
	General Practice / Specialist (cross out one)			
	Area of Speciality:			
<u>PLEASE NOTE:</u> <i>Retired doctors who wish to join the Association are required to attach a letter of good standing from their respective College.</i>				
<u>PROPOSERS:</u> (to comply with the Queensland Associations Incorporation Act, two financial members of the Association are required to nominate each applicant for <i>new</i> membership. Members <i>renewing</i> their membership do not need proposers).				
1. NAME:		Signature:		
2. NAME:		Signature:		
<u>ANNUAL SUBSCRIPTION (GST included):</u>		(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				
<u>Please note:</u> <i>Membership applications will be considered at the next Management Committee meeting.</i>				

The Sunshine Coast Local Medical Association has Public Liability Insurance

**SUNSHINE COAST LOCAL MEDICAL ASSOCIATION
MANAGEMENT COMMITTEE MEETING
THURSDAY 26 FEBRUARY 2015
Maroochydore Surf Club Function Room, Maroochydore
MINUTES
(Accepted at Committee meeting 26 March 2015)**

Attendance: Drs Di Minuskin, Rob Ingham, Nigel Somerfield, Scott Masters, Jenny Grew, Marcel Knesl, Kirsten Hoyle, Peter Dobson (SC Medicare Local), Wayne Herdy, Byron Oram, Jeremy Long, Mason Stevenson, Jo Bourke (Observer)

Apologies: Drs Peter Ruscoe, Denise Ladwig, Scott Phipps, Fiona McGrath.

Minutes of last meeting: 27 November 2014

The Minutes were accepted as a true and accurate record, pending a minor amendment to the Medicare Local Report – Dr Peter Dobson

- Correction ‘The boundary changes mean, for example, that the Sunshine Coast **Medicare Local is able** to bid for services for the Western corridor.

Moved: Nigel Somerfield Seconded: Jeremy Long.
Carried.

Business arising from Minutes. Nil.

President’s Report: *Dr Di Minuskin.*

Still in limbo wondering what the next version of Medicare reform will look like.

There appears to be a common message being sent to government now:

1. Access to quality and affordable medical care needs to be available to all the community.
2. General practice has consistently been the most economical tier of the health system. Government should not be looking to defund general practice.
3. Blocked access to primary care will increase costs as patients present later with complications of advanced chronic disease and increased dependence on more expensive secondary and tertiary care.
4. The sensible conversation should be about improving health outcomes not weighed down by cost. Improving health outcomes will reduce cost.
5. The business model of general practice must remain viable. The effect of any changes must be considered in regard to the effect on the various business models of general practice.

These points were covered in a meeting with Sussan Ley on 6th February and were a common theme at the AMA GP meeting on 8th February.

Vice President’s Report : *Dr Rob Ingham*

Nothing to report this meeting.

Secretary’s Report: *Dr Wayne Herdy*

Correspondence In: (*tabled Jenny Grew, Acting Secretary*)

- 23/12/14 – Office of Clive Palmer – acknowledgement of correspondence from Di Minuskin
- 02/01/15 – SC Daily Scott Sawyer – queries re copayment issue
- 12/01/15 – Specialistpoint – re Electronic Oncall Rostering
- 14/01/15 – Office of Clive Palmer – thank you for newsletter
- 15/02/15 – USC – re Donor Wall Recognition
- 15/01/15 – Emails between Mal Brough and Di Minuskin- re Medicare changes

Correspondence Out:

- Di Minuskin – reply to SC Daily Scott Sawyer – response to queries.

Business arising from Correspondence:

- Jo to respond to USC re Donor Wall Recognition.

Treasurer’s Report : *Dr Peter Ruscoe - Apology*

(a) Accounts to be paid: (*Tabled by past Treasurer, Dr Mason Stevenson*)

- Australia Post – Account January 2015
- Jo Bourke – Secretariat January 2015
- Office National – Account December 2014
- Snap Printing – February 2015 invites
- Snap Printing – February 2015 newsletter
- Jo Bourke – February 2015 newsletter
- Jo Bourke – Adobe CC sub December 2015
- Insurance – Directors and Officers
- ATO – BAS October – December 2014
- Chris Bourke – website updates
- Maroochydore Surf Club – February meeting
- Mullins – Website hosting

(b) Membership Report.

- Dr James Challen (Radiology, Sunshine Coast Radiology)
 - Dr Kathryn Jackson (Haematology Coastal Cancer Care, SCUPH)
 - Dr Rachel Sawyer (Emergency Medicine SCUPH)
- Members’ applications were accepted by the committee.

AMAQ Councillor’s Report: *Dr Wayne Herdy –*

Discussed impact of recent changes of Health ministers. The change at State-level is suspected not to be “doctor-friendly”. At a recent meeting with Redcliffe GPs, Sussan Ley conveyed her willingness to listen to doctors; it appears she will be a very good Minister of Health.

Meetings Convenor Report: *Dr Scott Masters*

- Months are filling up; September and November vacant. Discussion re ‘Spring Clinical’ for September meeting.

**SCLMA MANAGEMENT COMMITTEE MEETING
THURSDAY 26 FEBRUARY 2015
Maroochydore Surf Club Function Room, Maroochydore
MINUTES /cont:**

- Possible themes: 1. Clinical trials – what's available to enrol our patients; 2. Transition to SCUPH. Jo to explore sponsorship.
- Early planning for Christmas in July underway. Northern location (Noosa region) favoured and short list of suitable venues discussed. The band is keen! Date to be set, from possibilities of 18 and 25th July and 1 August.
- Meetings Convener will be an apology for next meeting.
- Changes to service provision have the potential to bring an innovative outlook for rural Queensland, ensuring a high level of care. If bids for services in the Western corridor are successful, for example, there will be a feed-in of patients to the Sunshine Coast region and accommodation suites are being suggested.
- With increasing emphasis on a "whole patient" rather than "disease-specific" focus, there is a need for improved data collection from general practice. Aims include improving and then implementing care plans followed by measurement of outcomes and increased publication of this data.

Hospital Liaison Report: Dr Jeremy Long

- SCUPH transition program progressing. Project management recruitment has occurred. The transition process includes 12-week "intensives" to focus on developing models of care with completion anticipated to be August/September. The process of mapping patient journeys is to include GPs and consumers. Where GPs would like to be involved in specific areas, such as cancer care, emergency department, diagnostic radiology, they should contact Sandra Peters (Hospital GP Liaison Officer).
- The ICT strategy for the SCUPH transition was discussed and although a recognised problem area, there are hopeful signs of a workable solution.

General Business:

- Website redevelopment was discussed by Marcel. A proposal will be distributed and feedback sought. Ideas include making the website tablet/device-friendly and improving revenue generation via advertising.

Meeting Close: 1907

Next Meeting – Thursday 26 March 2015

Venue: Maroochydore Surf Club Function Room

Medicare Local Report: Peter Dobson

- The process of bidding for the new Primary Health Networks is underway.

Dr Jenny Grew, Acting Secretary.

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"



Take Five

BUDDIES

Best friends, graduated from medical school at the same time, and decided, that in spite of two different specialties, they would open a practice together, to share office space and personnel, in Point Pleasant Beach, NJ.

Dr Smith was the psychiatrist, and Dr Jones was the proctologist. They put up a sign reading:

Dr Smith and Dr Jones: Hysterias and Posteriors.

The town council was livid, and insisted they change it.

The docs changed it to read:

Schizoids and Haemorrhoids.

This, also, was not acceptable; so they again changed the sign to read :

Catatronics and High Colonics – a no go.

Next, they tried:

Manic Depressives and Anal Retentives – thumbs down again.

Then came **Minds and Behinds** – still no good.

Another attempt, resulted in,

Lost Souls and Butt Holes – unacceptable, again!

So they tried **Nuts and Butts** – no way!

Freaks and Cheeks – still no good.

Loons and Moons – forget it.

Almost at their wits' ends, the docs finally came up with:

Dr Smith and Dr Jones – Specializing in Odds and Ends.

Everybody loved it.

TESTING TESTING

A group of women were at a seminar entitled "How to live in a loving relationship with your husband."

They were asked, "How many of you love your husband?"

All the women raised their hands.

Then they were asked, "When was the last time you told your husband you loved him?"

Some women answered today, a few yesterday, and some couldn't remember.

The women were then told to take out their cell phones and text their husband: **"I love you, sweetheart."**

The women were then told to exchange phones with another person, and to read aloud the text message they received, in response.

Here are some of the acceptable replies:

1. Who the hell is this?
2. Eh, mother of my children, are you sick or what?
3. Yeah, and I love you too. What's up with you??
4. What now? Did you crash the car again?
5. Don't beat about the bush, just tell me how much you need?
6. I thought we agreed you wouldn't drink during the day.
7. Your mother is coming to stay with us, isn't she?*

KILLICK ...

A "Killick" is an old navy slang word for a Leading Seaman, derived from his rank insignia of a rope fouled anchor(killick) on his sleeve.

A young Naval officer was in a terrible car accident, but due to the heroics of the hospital staff, the only permanent injury was the loss of one ear.

Since he wasn't physically impaired, he remained in the military and eventually became an admiral.

However, during his career he was always sensitive about his appearance.

One day the admiral was interviewing two Navy chaps

The first sailor was a surface weapon tech. At the end of the interview, the admiral asked :

"Do you notice anything different about me?"

"Why yes, said the young sailor I noticed that you're missing your starboard ear",

The admiral became angry at this lack of tact and threw him out of his office.

The last interviewed sailor was a three badge killick. He was articulate, and sharp,

The Admiral asked the same question.

"Do you notice anything different about me?"

"Yes, sir, said the killick, you wear contact lenses."

The admiral was very impressed he thought the killick was incredibly tactful "And how do you know that?" the admiral asked.

"Well, sir, it's pretty hard to wear glasses with only one bloomin' ear!"

TRIVIA

- Glass takes one million years to decompose, which means it never wears out and can be recycled an infinite amount of times!
- Gold is the only metal that doesn't rust, even if it's buried in the ground for thousands of years.
- Your tongue is the only muscle in your body that is attached at only one end.
- If you stop getting thirsty, you need to drink more water. When a human body is dehydrated, its thirst mechanism shuts off.
- Zero is the only number that cannot be represented by Roman numerals.
- Kites were used in the American Civil War to deliver letters and newspapers.
- The song, Auld Lang Syne, is sung at the stroke of midnight in almost every English-speaking country in the world to bring in the new year.
- Drinking water after eating reduces the acid in your mouth by 61 percent.
- Peanut oil is used for cooking in submarines because it doesn't smoke unless it's heated above 450F.
- The roar that we hear when we place a seashell next to our ear is not the ocean, but rather the sound of blood surging through the veins in the ear.

CLASSIFIEDS

CARDIOLOGY EQUIPMENT FOR SALE

Having now retired from practice Dr Tony Neaverson wishes to dispose of the following equipment

- Norav holter monitoring system
- 4 monitors still under lease
- 3 other back up monitors
- As new stress test treadmill and analysis
- Vo2 analyser (requires re calibration)
- Exercise bikes, treadmills and arm ergometer
- Resuscitation trolley, tanita body composition analyser

All offers considered

Ring Tony Neaverson **0428 408 351**

Equipment in storage at Noosaville

February 2015

TRINITY CLINIC, CALOUNDRA

- 2 x LUXO Examination Lights with extendable arms and rotational head (Wall mountable including brackets) \$100 each.

Contact Nadine Ware **5491 9888**

February 2015

CHANGE OF ADDRESS – DR SHARON HARDING

General Adult Psychiatry, Women's Mental health, Older Persons Psychiatry, Mood Disorders, Anxiety Disorders, PTSD and Trauma, Work-related injuries & Medico-legal

- The Sunshine Coast Private Hospital
- Cooina Clinic 12 Elsa Wilson Drive Buderim Qld 4556
- **Ph: 5452 0506 Fax: 5444 7299**
- Cooinda.clinic@uchealth.com.au

February 2015

COASTAL WOMENS HEALTH – MAROOCHYDORE - OPENING 2nd MARCH 2015

A new private clinic providing women's health services and managed by female General Practitioners with particular interests in:

- Well women checks
- Pap smears
- Breast checks
- Contraception management
- Sexual health checks
- Menopausal care

Appointments Ph: 5452 7349 or visit www.cwhc.com.au

Located on the 3rd Floor Cnr Esplanade & Second Ave, Maroochydore

February 2015

FEMALE GP REQUIRED O&G PRACTICE BUDERIM

This is an excellent opportunity for a female GP to join our Menopause and Weight Management Clinic located in Buderim on the beautiful Sunshine Coast Queensland. We are looking for a full time or part time VR or Non VR female GP to join our well established all female practice.

- Private Billing
- No weekend
- No after hours
- Remuneration negotiable

For further information please contact Dr Dana Moisuc or Danielle Gage - Practice Manager on **ph: 5478 3533** or email: reception@danamoisuc.com.au

February 2015

PROFESSIONAL OFFICES AVAILABLE FOR LEASE

Nucleus Medical Suites, The Sunshine Coast Private Hospital, Buderim.

- Two consulting rooms with minor procedure room.
- Recently completed rooms in modern specialist medical building. Free parking.
- Available on long-term or sessional basis.
- Facilities in place for an independent, co-located practice or sharing of systems and administration support can be arranged.

Enquiries: dcolledge@effel.net.au

February 2015

SPECIALIST ROOMS AVAILABLE FOR LEASE

Sunshine Coast General Surgeons have modern specialist rooms available for lease on the ground floor of the Sunshine Coast University Private Hospital.

- Available on a full-time basis or for sessional times.
- Included in the lease are electricity and cleaning.
- We are able to offer full secretarial services if required.

Please contact our practice manager, Robyn Blackmore, for further information

Ph: 5493 7018, Email: reception@scgensurg.com.au

February 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.*

SCLMA monthly clinical meetings

Please help us have fewer 'no-shows' and spare a thought for our sponsors and caterers!



April 23rd Meeting Stats:

Original number of acceptances = 72

Minus 7 apologies received (thank-you!)

Minus 7 no-shows

Plus 4 extras on the night.

Total: 62 in attendance.

Final number given to Surf Club (two days before) was 70 so the sponsors were required to pay for that number (as usual).

SCLMA CLINICAL MEETING - 26 MARCH 2015

Maroochydore Surf Club Function, Maroochydore

Dr John Evans - *'Optimising Spinal Injections'*

Dr James Challen - *'Calcific Tendinopathy, Tennis Elbow and Plantar Fasciitis'*

Sponsor: Sunshine Coast Radiology



Presenter Dr John Evans
from Sunshine Coast Radiology



Parisa Mehdipour and Tremaine Permewan,
Sponsors - Sunshine Coast Radiology



Dr Clint Herd with new SCLMA member,
Dr Gus Ferguson



Presenter Dr James Challen
from Sunshine Coast Radiology



Left:
Dr Stacey Wirth,
Dr Karien Treurnicht
and Dr Lisa Knesl

Right: Dr Andrew
Southee

