NEWSLETTER
September 2014

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

Firstly, I would like to thank the members for their support in allowing me to remain President for a further year. It has been a steep learning curve but the role has been made easier by the hardworking committee that will remain intact for a further 12 months. I would also like to welcome Jenny Grew onto the committee and look forward to her valuable contribution.

I am writing this report from the USA. I am currently on route from San Francisco to Chicago, before an early morning flight onto New York City. Holidays are wonderful but getting there is always such a challenge. I was still throwing things in a suitcase a few hours before the flight. Extra appointments had to be scheduled at the surgery to fit in all the urgent cases before I went away. Why is it that patients decide the rash they have had for 2 months is suddenly urgent when they hear you are going away for 2 weeks?

A few days ago, I attended a meeting where Professor Martin Connor spoke about what primary care might look like under the new Primary Health Networks. This is a model that has been reincarnated several times now and we are all waiting to see what "Phoenix" might rise from the ashes on this occasion. He also detailed some of the data and patient management processes that are being successfully employed on the Gold Coast. It was pleasing to hear him highlight patients focused pathways with acknowledgment of the family doctor as having a central role. Again, as I have mentioned numerous times, barriers to communication must be taken down for both the benefit of the patient and also efficiency of the system. Access to advice from the hospital might prevent an unnecessary referral, and a quick access to the GP might prevent tests being repeated that have already been done.

There is great expectation that the redeveloped SCHHS website will be a great "go to" tool for navigating the hospital referral pathways. However, I would also encourage anyone who remains uncertain about a process or indeed post discharge care in complex patients, to pick up the phone and ring our colleagues at the hospital. In my experience, this has been invaluable at times.

In my absence from Australia and the current inertia in resolution of the federal budget issues, I am going to share with you a story of why general practice is such a wonderful speciality. It should not be considered the default career for those who do not obtain a training position in the other specialities.

Last week, we lost a child to cancer in my practice. I had diagnosed this young fellow at 2 years of age with his tumour and had watched him bravely face 5 years of craniotomies, radiotherapy and cycles of chemotherapy. Eventually it was evident that the tumour had reached an untreatable stage. He was sent home to die. Paediatric palliative care, fortunately is something that I rarely have to do, so my skills with drug doses etc needed some quick revision. However, what I was able to bring was a 15 year relationship with the family. The Royal Children's Hospital gave amazing support, and I had 24 hour access to advice. But in the end, what was just as important as pain free journey for our young patient, was the support that the family needed.

On a happier note, I have now arrived in New York. We are looking forward to a week of shows, shopping and dining. I feel quite at home in NYC (my husband was born here) but my travelling companions have not been here before. They are keen shoppers so I am sure that 5th Avenue (window shopping only) and Macy's will be on the itinerary! Home again in two weeks with some stories from the Big Apple!

Di Minuskin

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
FHN Rep:	Dr Scott Phipps Ph: 5494 2131
Committee:	Dr Kirsten Hoyle Dr Denise Ladwig Dr Byron Oram Dr Mason Stevenson Dr Nigel Sommerfeld Dr Jenny Grew

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

OCTOBER 2014 NEWSLETTER

Deadline Date for the OCTOBER 2014 newsletter will be FRIDAY 9th OCTOBER.

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

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

Contact Jo: 5479 3979
Mobile: 0407 037 112
Email: jobo@squirrel.com.au
Fax: 5479 3995

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

ARE YOU A MEMBER?

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

www.sclma.com.au.

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

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

Directory form available on the website.

Editors Column-

Welcome to the September 2014 newsletter.

August heralded the start of a new year for the SCLMA with the AGM reappointing all current committee members and ushering in a new committee member in Dr Jenny Grew.

Jenny is well known in the field of pathology currently presenting as a guest speaker at several Sunshine Coast Oncology Seminars events.

September also sees the end of the Focus Health Network team. I have included below a paragraph from the FHN eNews in regards to a message from the FHN CEO Phil Johnson:

> *"As you may be aware, the Focus Health Network Board recently resolved that FHN will cease its operations at the end of September 2014.*
>
> *The FHN team is currently working to transition its active programs and services to other organisations. Our goal is to maintain continuity of delivery with minimal disruption to clients of those programs and services."*

On behalf of the membership of the SCLMA I would like to thank the FHN team and wish them well with future endeavours.

Last month I briefly touched on the high cost of living. One way in which the cost of living will come down over the coming years is through online shopping. I refer you to this week's motoring column. Online shopping spins out in the direction of motor vehicle tyres. The motoring column this month draws our attention to what can be achieved through online shopping. An excellent read and definitely something which I will be pursuing the next time my tyres need replacing.

International elections, Fiji, Scotland and New Zealand, have dominated the media headlines. This together with the current state of IS seems to over shadow local politics.

I think it is time to re-watch Mel Gibson in Braveheart! Go the Scots.

Regards,
Marcel Knesl
mknesl@oceaniaoncology.com

HIGHLIGHTS:

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

THURSDAY 23 OCTOBER 2014

Speaker: **Dr Karl Schulze**
Topic: ***A Vascular Surgical Update***
Sponsors: **Sunshine Vascular and Covidien**
Venue: **EBB Waterfront Restaurant**

(Dr Shaun Rudd, President, AMA Qld will attend this meeting to network members and address the meeting briefly)

THURSDAY 27 NOVEMBER 2014

Speaker: **Dr Brenda Heyworth**
Topic: ***A Practical Approach to Diagnosis and Treatment in Child Psychiatry***
Speaker: **Dr Erica Baer**
Topic: ***Child Protection Reforms - what has changed and what hasn't?***
Sponsor: **The Property Clinic (Paddy Guildford)**
Venue: **Maroochydore Surf Club**

(Nina Colina, SCLMA Bursary Recipient, University of the Sunshine Coast will attend this meeting to give a brief overview of her field of study)

ENQUIRIES:

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

Meeting attendance:

- ***Free for current members.***
- ***Non members: $30. ($50 for Ebb)***
- ***Application forms available on night.***
- ***Membership forms also available on the website: www.sclma.com.au***

Hospital in the HOME

Hospital in the Home (HITH) is a new service being offered by the Queensland Government and the Sunshine Coast Hospital and Health Service (SCHHS).

HITH involves the provision of acute care at a patient's usual place of residence as a substitute for inpatient care at a hospital. HITH is a priority commitment for the Queensland Government. The government's Blueprint for better healthcare in Queensland, launched in 2013, encourages the increased use of HITH.

Several national and international reviews have prompted the use of HITH as a model that:

- has the potential to provide patients with greater choice in their care
- improves access to health services
- provides equal or better patient care outcomes
- improves efficiencies in service delivery.

HITH consists of a virtual ward where the patient is classified as an inpatient for the duration of the episode of care. Silverchain HITH team and their partners provide 24 hour a day hospital-level care, within their home environment. Admission to these virtual beds is under the medical governance of the Silverchain HITH medical officers or the SCHHS medical officers. Patient review is conducted via telehealth or as a scheduled clinic review.

Admission criteria encompass clinical, social and service requirements. Five common conditions treated under the HITH model of care include: cellulitis, pulmonary embolism, urinary tract infections, respiratory infections and venous thrombosis.

HITH patients have to meet specific eligibility requirements including:

- an appropriate diagnosis for management of their condition at home
- clear medical professional nominated for directing the treatment plan and conducting medical reviews
- medically stable
- patient consent
- able to communicate effectively either directly or through an interpreter or nominated guardian
- access to and be able to use a telephone, with available credit and service if mobile
- adequate social supports to return to the home environment
- safe and appropriate environment for care delivery for care
- cognitive and physical state must be conducive to care external to the hospital
- reside within the SCHHS.

The HITH program will focus on the transfer of care, including quality referral and discharge processes so that a continuum of care is provided. A discharge summary will be sent to the regular treating general practitioner on discharge from HITH. There are statewide key performance indicators to monitor the success of the programs and identify areas of improvement.

Silver Chain
Ph: 1300 466 346

Hospital in the home guideline
www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-379.pdf

Sandie Pott
Project Manager, Sunshine Coast Hospital and Health Service
Ph: 0407 762 386

Great state. Great opportunity.

Silver Chain

Queensland Government

HEALTH SERVICE LINK
September 2014

The Sunshine Coast Hospital and Health Service (SCHHS) has established a new ***Hospital in the Hom*e (HITH)** service. We are partnering with Silver Chain who are experienced in delivering such care, having provided large-scale HITH service in Western Australia for some time.

HITH provides 24/7 hospital-level care within the home environment with the assistance of nursing and allied health staff, so patients can receive hospital level care in the comfort of their home. Admission to these 'virtual' beds is under the medical governance of GPs associated with Silver Chain or SCHHS medical officers. Plans are in place to further develop the service, including increasing the number of GPs involved to enable more referrals to the program.

Admission criteria include clinical, social and service requirements and a patient review is able to be conducted via telehealth or through a scheduled clinic review.

HITH patients need to meet specific eligibility requirements, some of which are listed below:

- Medically stable
- Referring doctor agrees that care can be safely provided at home
- Patients / carers agree to follow the treatment regime at home
- Patient consents to HITH

The HITH program places emphasis on transfer of care, i.e. referral and discharge processes to ensure continuum of care. A discharge summary is sent to the patient's regular GP on discharge from HITH on the Sunshine Coast.

As at 25 August 14 there have been 23 patient referrals to the HITH program. Ongoing telehealth support has seen 27 reviews conducted. The service has received very positive feedback from patients.

Information fliers have been shared with our primary consumers including General Practitioners, Nursing Homes, Domiciliary Nursing Services in the Primary Care Community and non-government organisations.

Referrals can be made by contacting the Community Hospital Interface Program Team or Silver Chain's referral line 24/7 on **1300 466 346.**

HITH guidelines are available at www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-379.pdf

Any other questions should be directed to Sandie Pott, Project Manager, Sunshine Coast Hospital and Health Service on **0407 762 386.**

Kevin Hegarty

Health Service Chief Executive

Sunshine Coast Hospital and Health Service

Kevin.Hegarty@health.qld.gov.au

AMA QUEENSLAND PRESIDENT'S REPORT

Dr Shaun Rudd

Dear members,

As you may know, I recently visited Central Queensland as part of my first President's Tour. Though my role frequently brings me to Brisbane, I always look forward to the opportunity to chat with members across the state about the issues affecting them.

This visit, which brought me to Rockhampton and Gladstone, was a great opportunity to chat with our Central Queensland members about their concerns and what's affecting their areas. I enjoyed the opportunity to visit the local clinics and hospitals, but primarily I enjoyed the chance to meet members at our hospital lunches and member dinners.

The concerns and challenges medical practitioners in Queensland face are as diverse as the state itself. Because of this, the feedback we get from Local Medical Associations and members is instrumental at developing our member advocacy work, member support and offerings to ensure we are best supporting the interests of all our members.

This tour was particularly timely given we recently kicked off our Lighten Your Load campaign addressing obesity in regional areas. Thus far, this campaign has been a great success, and I enjoyed the opportunity to chat with media in the area and encourage Central Queenslanders to address this growing problem.

In recent weeks, AMA has advocated for several rural health measures that seek to ensure rural Australians have access to quality care.

AMA recently released a position statement on the proposed "Easy Entry, Gracious Exit" Model for Provision of Medical Services in Small Rural and Remote Towns. This model would allow GPs to practice in rural areas without the commitment or financial burden of becoming a business owner.

Additionally, AMA has called on the Government to implement Regional Training Networks that would increase rural training opportunities and increase the likelihood of attracting junior doctors to these areas.

These would be welcome measures in Queensland, where a high rural population and large distances can create challenges for patients in accessing care. Statistics from the Australian Institute of Health and Wellbeing demonstrate that health outcomes are notably lower in rural areas as opposed to metropolitan. There is no reason rural Queenslanders shouldn't be able to access the same care as those in the major cities, and we welcome any initiatives that make quality care tangible for all Queenslanders.

It is hard to believe the year is 2/3 of the way over. The last few months of the year are always a busy time at AMA Queensland with our Annual Conference, Intern Workshops and Events and our Private Practice Series. I hope you'll take advantage of these offerings and I look forward to what we'll be able to accomplish in the last part of the year.

Sincerely,

Dr Shaun Rudd

AMA Queensland President

WOULD COPAYMENTS MAKE ETHICAL RATIONING POLICY?

Dr Wayne Herdy

During the World Wars, there were shortages of most consumer products. In Australia, that was either because items such as petrol were fully imported, or because there was a shortage of labour to produce items such as food. Governments introduced frank rationing. Individuals were issued with ration cards that allowed them to buy basic essentials – many foods, clothing, and petrol – but only in limited and prescribed amounts. The ration card was a permit to purchase, and the consumer still had to pay for the product, if they had enough money. Many ration cards remained unused, either because the consumer did not perceive that they needed the item that the government thought they needed, or because they could not afford it anyway.

There were two main purposes to rationing: to reduce the consumption of limited resources, and to allow selected individuals to buy essentials according to need rather than according to capacity to pay. The "need" was determined by government policy – children could buy more clothes and doctors could buy more petrol. The principle was frequently corrupted – the wealthy could buy ration cards that the poor were prepared to sell on the black market.

In a pure market economy, those who are prepared to pay a lot for an item can buy it at a price beyond its real value. Buyers can prevent items being purchased by others who cannot pay as much (or are not prepared to pay as much). Rationing supposedly prevented the wealthy from buying unfair quantities of items that the poor could not buy.

The GP co-payment proposal is a rationing strategy. It is intended to reduce the consumption of a resource that is limited – not GP services themselves, but the money that pays for GP services.

As a rationing strategy, it fails the ethical principles of rationing.

Firstly, the item in short supply, GP funding, is only in short supply because government policy refuses to direct enough of the health budget away from expensive and inefficient high-tech but low-output interventions and into the cheap and efficient, lower-tech and higher-output, primary care services.

Secondly, it is possible that the GP co-payment will affect the wrong target population, and may eventually not affect rates of attendance as much as predicted. It is certain that the GP co-payment will work as a rationing device in the short term, because it will stop a lot of patients from attending GPs .

Patients who avoid the cost of GP consultations might be those who genuinely can't afford it, but will include many who can afford the cost but just refuse to pay for a service that they are accustomed to receiving without direct cost.

In the longer term, there is a possibility that, when patients become accustomed to the presently-unfamiliar idea that all patients will make a contribution to the cost of a consultation, they will revert to a rate of consumption not much different from the present rate of consumption. If so, the rationing will fail. The final outcome will be similar rates of GP attendances to present rates, but at lower unit cost to the government and higher cost to individual patients.

Thirdly, an ethical rationing process will ensure that access to GP services will be dictated by need, not by ability to pay. In the initial proposals, the GP co-payment was going to strongly favour those with deep pockets and substantially exclude those with limited financial means. Ration cards were issued in wartime to those who most needed the scarce resource – babies could preferentially get milk when others could not. The co-payment proposal was going to achieve the exact opposite – patients with chronic disease and disadvantages would experience greatest difficulty getting access to health resources even though their real need is undeniably greatest. Even the AMA alternative, to simply exclude disadvantaged groups from the co-payment, would not satisfy rationing theory. Ethical rationing would create an environment in which those who most need GP services would not merely be exempted from the rationing barrier, but would have positive assistance in getting access to health services. In its purest ethical form (shorthand for saying that this will probably never happen) rationing of GP services would give priority to those with proven greatest need, and limit the amount of those services consumed by those whose real need is not so great.

So, what is the answer to the question at the head of this article? A resounding "no". Apart from what we have already speculated as practical outcomes to implementing co-payments, the policy also fails the abstract theories underlying the philosophy of rationing.

The opinions in this article are those of the author and do not necessarily reflect the policies or values of the AMA or this LMA.

Wayne Herdy.

Tribalism:

The real enemy in healthcare

Five doctors went duck hunting one day. Included in the group were a general practitioner, a paediatrician, a psychiatrist, a surgeon and a pathologist.

After a time, a bird came winging overhead. The first to react was the GP who raised his shotgun, but then hesitated. "I'm not quite sure it's a duck," he said, "I think that I will have to get a second opinion." And of course by that time, the bird was long gone.

Another bird appeared in the sky thereafter. This time, the paediatrician drew a bead on it. He too, however, was unsure if it was really a duck in his sights and besides, it might have babies. "I'll have to do some more investigations," he muttered, as the creature made good its escape.

Next to spy a bird flying was the sharp-eyed psychiatrist. Shotgun shouldered, he was more certain of his intended prey's identity. "Now, I know it's a duck, but does it know it's a duck?" The fortunate bird disappeared while the fellow wrestled with this dilemma.

Finally, a fourth fowl sped past and this time the surgeon's weapon pointed skywards. BOOM!! The surgeon lowered his smoking gun and turned nonchalantly to the pathologist beside him and said: "Go see if that was a duck, will you?"

Source: NursingFun.com

What's great about this joke is not just the stereotype behaviour of the five doctors – which most of us immediately will recognise. What is wonderful here, is the different disciplines doing some team building. They may not be very efficient as a team yet, but at least they have found a common goal: shooting ducks.

In the real world of medicine we sometimes seem to have forgotten our purpose. The inconvenient truth is that we're often acting as a dysfunctional team where every member's main goal is to finish their own task, and where other team members (disciplines) are sometimes regarded as 'the enemy'.

A while back I was privileged to hear Dr Victoria Brazil speak at a conference of the Royal Australian College of General Practitioners in Brisbane. Dr Brazil is an emergency physician and passionate about the topic of medical tribalism. Instead of the more primitive tribal behaviour – characterised by hostility towards other tribes and the unwillingness to take responsibility for a bigger cause – we should move to a kinder tribalism driven by mission and purpose, without common enemies, she argues.

Dr Brazil reminds us that we cannot achieve the best patient outcome without other disciplines. Building relationships, communicating and networking are the key to success. This sounds obvious but it's not very often that we make time to sit down and have a yarn with members of other teams.

You don't have to go duck hunting together, but next time you talk to someone belonging to a different tribe, why not introduce yourself and ask how they're going?

Edwin Kruys is a Caloundra GP who blogs at doctorsbag.net

GPLO UPDATE SEPTEMBER 2014

You have all undoubtedly heard by now that Focus Health Network will cease to trade from the end of this month. I would like to acknowledge the support their staff has offered to general practice over several years in their incarnation first as the Division of General Practice and latterly as Focus Health Network. For many practices the IT support as we moved into PKI encrypted communication was particularly invaluable. I would like to extend my personal thanks to the FHN staff with whom I have worked over recent years in the GP liaison role - I wish you well for the future.

A reminder that the Referral Work up Guide is to be found on the SCHHS website. www.health.qld.gov.au/sunshinecoast/ It is anticipated that the updated version will be completed and published on this website in the near future. We are continuing to update the information we have on services offered in general practice, through a combination of phone calls and emails to practice managers. By sharing this information we hope to improve access for patients to the care they require in a timely fashion. Whilst practice contact details will be listed on the website (where practice mangers have provided consent) please be assured no personal email addresses will be published.

Work continues to develop integrated models of care involving GPs and specialists in a number of areas. Most recently an expression of interest was emailed inviting applications from GPs to participate in a Women's Health Service. It is anticipated there will be similar initiatives evolving over the coming year as we work towards building closer links between primary and secondary care, and improving access for patients across the Sunshine Coast.

For further information about this or any other matter please contact me at :

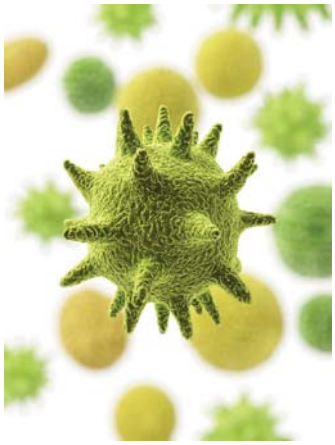
Sandra.peters@health.qld.gov.au or **(07) 5470 6541**

Best wishes

Sandra Peters

SOME THOUGHTS ON ALLERGIC RHINITIS

"Hay fever is both positive and negative – sometimes the Eyes have it, and sometimes the Nose"… apologies to William L Phelps.



Spring and summer, great for some, but for others, the seasons herald flourishing plants which toss out pollens by the millions [and probably billions] into the air. These enter eyes, noses, mouths and lungs causing sneezing, rhinorrhea, itching and watering eyes, and in some, wheezing and coughing. For many, these are only a nuisance, but for a significant group the symptoms are so severe that they make life a misery at that time. They become tired, can't concentrate or think clearly and simply can't function optimally at work or at school. Indeed studies of school children at those times of year show that their academic performances are reduced. This is particularly relevant because these seasons correlate with major school examinations.

Some studies have shown that as many as 40% of the population has suffered some degree of hay fever through their lives. Even if only 5% of these have major symptoms [a very conservative figure], allergic rhinitis represents a major medical problem in the community.

There is often confusion about the types of plants responsible for the seasonal symptoms. As a rule flowering plants such as wattle, jacaranda, gum trees, 'bottle brushes', etc, are not the culprits – they rely on bees, birds or other insects for cross pollination. Rather, those causing the symptoms are mainly grasses, a few weeds and only certain trees such as Bribie Island pines and perhaps melaleuca.

Of course pollens are not the only airborne allergens. Perennial triggers include house dust mites, mould spores, cats and to a lesser extent dogs and horses, with guinea pigs becoming more common lately. In regard to animals, there are misconceptions re the specific allergens. It is not their hairs or fur, but saliva from cats and dogs, sweat from horses and urine from guinea pigs, rats and mice! This is a simple explanation for the reason that cat allergy is far more common than dog allergy.

For those with significant hay fever, avoidance of the allergens would be the desirable approach but for most this is not feasible. Medical intervention is necessary for them. This includes symptomatic measures – antihistamines, saline douches, and decongestants [but be careful with decongestant nasal sprays] and/or suppressive/preventative agents such as topical nasal steroids.

For those who are debilitated by hay fever, specific immunotherapy may be the best approach. It has the ability to cure the condition, or at least give marked improvement without reliance on medication.

Dr Graham Solley

Allergy Specialist & Immunologist

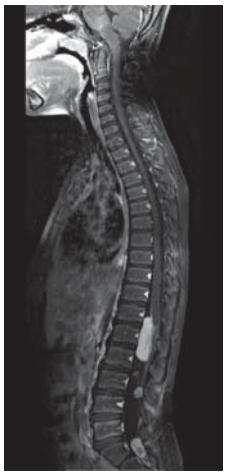
Dmyxopapillary Ependymoma

SUNSHINE COAST RADIOLOGY

Findings
Extensive intradural avidly enhancing tumor distorting the conus & cauda equina. Multiple skip lesions are also noted.

Diagnosis
Findings are in keeping with myxopapillary ependymoma.

Discussion
Spinal myxopapillary ependymomas are a variant type of spinal ependymoma that occur exclusively in the conus medullaris and filum terminale. They represent 13% of all spinal ependymomas [3] and are by far the most common tumours of the conus medullaris and filum terminale.



Epidemiology
They tend to have an earlier clinical presentation than other spinal ependymomas, with a mean age of presentation of 35 years. There is a slight male predominance.

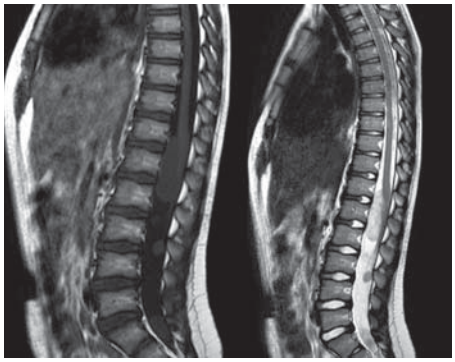
Clinical presentation
The most common presenting symptoms are low back, leg or sacral pain. Up to twenty five percent of patients may present with leg weakness or sphincter dysfunction. They may occasionally present as a subarachnoid haemorrhage.

Pathology
They are thought to arise from the ependymal glia of the filum terminale or conus medullaris.
Histologically, they contain papillary elements in a myxoid background, admixed with ependymoma-like cells.
They are generally classified as WHO grade I lesions, however occasionally CSF dissemination occurs and multiple lesions are seen in 14 - 43% cases. They are typically multilobulated and encapsulated. They often have associated haemorrhage, and may calcify or undergo cystic degeneration. The vast majority are intramedullary, however rarely they occur in the extradural space.

Radiographic features
Plain film / CT
If they become large, myxopapillary ependymomas may expand the spinal canal, cause scalloping of the vertebral bodies and extend out of the neural exit foramina.

MRI
Smaller tumours tend to displace the nerve roots of the cauda equina; larger tumours often compress or encase them.
Reported signal characteristics include

- T1
  - usually isointense
  - prominent mucinous component occasionally results in T1 hyperintensity
  - haemorrhage and calcification can also lead to regions of hyper- or hypointensity
- T2 :
  - overall high intensity
  - low intensity may be seen at the tumour margins because of haemorrhage (myxopapillary ependymomas are the subtype of ependymomas that are most prone to haemorrhage)
  - calcification may also lead to regions of low T2 signal
- T1 C+ (Gd) :
  - enhancement is virtually always seen
  - the enhancement pattern is typically homogeneous, however they can have a variable enhancement pattern that, in part, depends on the amount of haemorrhage present



Treatment and prognosis
Myxopapillary ependymomas are generally slow-growing, although some sacral and presacral lesions behave aggressively and metastasise to lymph nodes, lung and bone.
They can often be excised completely. In these cases, prognosis is excellent. If the tumour has extended into the subarachnoid space and surrounded the roots of the cauda equina, resection is often incomplete and local recurrence is likely.

Differential diagnosis
Differential diagnosis of a small conus and filum terminale myxopapillary ependymoma includes :

- spinal schwannoma (often indistinguishable from ependymoma)
- spinal paraganglioma

Differential diagnosis of a large myxopapillary ependymoma that causes sacral destruction :

- aneurysmal bone cyst - involving the spine
- chordoma
- giant cell tumour - involving the spine

REFERENCES
http://radiopaedia.org/articles/spinal-myxopapillary-ependymoma

MEDICAL MOTORING

with Dr Clive Fraser

"Doctor, why am I so tyred all the time?"

Buying tyres on-line .....

The internet has revolutionized so much of the World around us.

It makes you wonder how we read the news, booked an airline ticket, sent a letter or even met before the world wide web came along.

How did we keep ourselves occupied before we had Wikipedia, Facebook, Twitter, Instagram, Snapchat and YouTube?

And who was it who decided to place a capital letter inside so many techno neologisms?

Whilst on-line dating seemed like a Mecca for stalkers and an unorthodox way to meet not that long ago, my younger colleagues assure me that it's now very much the norm.

The logical consequence of all that data traffic is the gradual decline of the traditional means of performing many tasks.

The most obvious evidence of this is the gradual extinction of Newsagencies.

For years they were protected businesses with a monopoly on the sale of newspapers in their local area.

Just like the "Rivers of Gold" that flowed from their classified columns.

But that monopoly is worthless when people stop buying newspapers, when no one sends cards anymore and people search for Unique Cars on-line rather than in a printed magazine.

I'm predicting that the Real World will be completely replaced by the Virtual World sometime before Christmas.

I've just discovered that the latest retail offering to go on-line is the purchasing of car tyres.

Until recently I'd entrusted all advice on tyre purchases to a beloved local guy called Dave who'd watched my family grow up and who always knew exactly the right rubber to put between myself and the road.

PZERO

I never bothered to shop around because I knew that Dave would look after me with the best price and the best advice.

But a colleague with a Range Rover started looking for a cheaper price on-line after discovering that his 20 inch tyres were around $700 a piece.

Those 20 inch rims meant a very low profile configuration that also made the tyres rather prone to damage on kerbs.

Somewhat relieved to have finally worn out a set after 45,000 kilometres he made that familiar telephone call to his local tyre guy and was pleasantly surprised by a quote of $578 each for Pirelli PZero 245/45R20 99Z tyres (ie $2,312 per set of four).

Not exactly expecting to find a better price at another outlet and denying that he was back on the dating web-sites he somehow searched on-line and found a site called www.tyresales.com.au.

By either searching for his make and model or the tyre size directly that same Pirelli tyre came up as $311 fitted and balanced!

That's $1,244 for four tyres and a saving of $1,068 on a full set.

Checking twice in disbelief to be sure he then ordered and paid for his tyres on-line and had the option of having them fitted at any one of 1000 locations in Australia.

MEDICAL MOTORING /CONT ....
with Dr Clive Fraser ....

At www.tyresales.com.au most of the Fitment Centres are new car dealerships which are re-assuringly still made of bricks and mortar.

But as fate would have it his fitting location was back at the same dealer he'd obtained the original $578 quote from.

So would I buy my next set of tyres on-line?

Absolutely.

Sorry Dave.

PS There is an additional $10 freight charge per tyre for non-metropolitan delivery.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

GP Education

Doing it for Doctors
PARTNERS IN GP EDUCATION

Hearts

- your guide to complete cardiac care and maintenance on the Sunshine Coast

Sunshine Coast University Private Hospital presents an Active Learning Module in practical cardiovascular care featuring absolute cardiovascular risk – caring for the heart in general practice, a series of cardiac cases, ECGs and cardiology workshops.

Sunshine Coast Heart Specialists:
Mark Johnson, Peter Larsen, KK Lim, Rohan Poulter, Stuart Butterly, Alex Willson & Naresh Dayananda

Heart Care Sunshine Coast: Tau Boga & Jonathan Cherry

Program

9.30am	Registrations
10.00am	Welcome and introductions
10.05am	**Absolute cardiovascular risk**
11.00am	**Cardiac case discussions** • STEMI • Advanced cardiac imaging in the cath lab • Heart failure • Cardiac conditions you can't afford to miss
1.00pm	Lunch
2.00pm	**Workshops** ECGs 101 – the basics for general practice and where to get help Cardiac imaging – a quick and easy guide for GPs
3.00pm	**Cardiac work stations** • Echocardiogram • Pacemaker / ICD • PCI station • CTCA station
4.00pm	Evaluation & Close
4.00-5.00pm	Post conference drinks & hors d'oeuvres

When: **Saturday, 25 October, 2014**
9.30am – 4.00pm

Where: Pelican Waters Golf Resort & Spa, 38 Mahogany Drive, Pelican Waters Qld 4551

RSVP: Friday 17, October, 2014

Approved 40 QI&CPD Category 1 points

Proudly sponsored by

Sullivan Nicolaides PATHOLOGY Quality is in our DNA

Pfizer

Boston Scientific Advancing science for life™

Register online at
www.sunshinecoastuniversityprivate.com.au

OR

Or Scan this QR Code

Email Pam Bull at bullp@ramsayhealth.com.au
Further information call 0427 327 321
Limited accommodation available at Pelican Waters, please contact Krystle in the Events Department on 07 5437 4633.

If you wish to be removed from our mailing list please **email** bullp@ramsayhealth.com.au

SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL

People caring for people

RAMSAY HEALTH CARE

We didn't want you to meet our new Cardiologists for the first time...like this.

SUNSHINE COAST HEART SPECIALISTS
your leading heart team

Dr Mark Johnson

Dr Peter Larsen

Dr KK Lim

Dr Rohan Poulter

Dr Stuart Butterly

Dr Alex Willson

Dr Naresh Dayananda

So we thought we'd just introduce them to you instead.

The introduction of Interventional Cardiology at Sunshine Coast University Private Hospital is a significant first step in establishing comprehensive cardiac services at the Coast's central health hub.

Direct access to leading edge technologies assures individuals with cardiac problems of rapid assessment and immediate intervention for life threatening conditions.

Our highly skilled and experienced team of health professionals and cardiologists are on hand twenty-four hours a day to deliver best practice clinical outcomes in our dynamic cardiac and cardiac angiography units.

HeartCare SUNSHINE COAST

Dr Tau Boga

Dr Jonathan Cherry

The new private hospital, now open at Kawana, offers a comprehensive range of acute medical and surgical services to the Sunshine Coast community.

Supported by 6 state-of-the art operating theatres, cardiac catheter laboratory, minor procedure room, day surgery unit, intensive care unit and day oncology unit, our team of specialist doctors and compassionate, dedicated staff will provide you with the best possible care and support.

World class cardiac care that's just around the corner.

*Sunshine Coast University Private Hospital...**new hospital, new level of care!***

www.sunshinecoastuniversityprivate.com.au

SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL

LUMP SUM SUPER DEATH BENEFITS TO ADULT CHILDREN

Poole Group
ACCOUNTANTS & INVESTMENT ADVISERS

Background

The relationship between a superannuation member and beneficiary at the time of death determines the tax payable on the death benefit and whether the benefit can be paid directly to the beneficiary or to the deceased's estate and then distributed to the beneficiary. If the beneficiary is a dependant for superannuation purposes, they are able to receive a superannuation death benefit paid directly from the fund. Children of any age qualify as a dependant for superannuation purposes. However, harsh tax rates can apply (up to 32%) if the child is over the age of 18 and no longer financially dependent on the deceased member.

Paid directly from super fund

Where death benefits are paid directly from the deceased member's superannuation fund, the fund will withhold tax on the benefit depending on the tax components. The adult child will then include the taxable component of the death benefit in their assessable income.

Paid via estate

Where a lump sum death benefit is paid to the deceased member's estate, then distributed to an adult child beneficiary, the superannuation fund does not withhold tax. To the extent that proceeds will be directed to an adult child, the executor of the estate must treat the taxable element of the death benefit as income for which no beneficiary is presently entitled. This means the executor is responsible for paying tax on the benefit and the beneficiary does not need to include the benefit in their tax return. Deceased estates are not liable for Medicare Levy which can make it attractive to have benefits distributed via the estate rather than directly from the superannuation fund. The estate will receive a tax offset to ensure it pays no more than 15% on the taxable (taxed) element and 30% on the taxable (untaxed) element.

Impact on Government entitlements

Lump sum superannuation death benefits paid via a deceased estate are treated as non-assessable non-exempt income when received by the adult child. In this case, the payment will not generally have a detrimental impact on Government entitlements affected by assessable or taxable income such as Family Tax Benefit A or B, HECS repayments, child support payments, low income tax offset etc.

Other considerations

In addition to tax and social security implications, there are a number of other issues that need to be considered when determining whether to nominate an adult child or the estate as the beneficiary of a superannuation death benefit such as simplifying administration of the estate, ensuring the benefits reach the intended beneficiary and Anti-detriment payments. Clients should consult their financial adviser, accountant and solicitor when considering nominating adult children for life insurance benefits and/or superannuation assets.

If you have a question please call Hayden White at Poole Group on **07 5437 9900.**

Reference: Colonial First State, FirstTech Update Edition 87 – July/August 2014.
Article by Hayden White DFP & Cert IV Finance/Broking

The Prince of Pinots

Grant Taylor

dr. plonk

Grant Taylor is a visionary .....

From humble viticultural beginnings, Grant has forged a name for himself as one of the greatest Pinot Noir makers in the world. He is the only person to be coveted with the award as World's best Pinot Noir maker three times at the London wine show. Perhaps an Italian heritage, as indicated by his Great Grandfathers Giuseppe Valli, immersed in food and grape growing is to be thanked.

He is a humble man with a vision to make Pinot Noir that represents the terroir it births from. It's a goal of his to have Central Otago Pinot Noir known as a style and similar to the Appellation of French houses of Burgundy.

He has been based 30 years in the Central Otago region and has wines that represent The Gibbston Valley, Bannockburn region, Bendigo and the Waitaki region in North Otago: a new geographe of wine origin .Riesling is made from the Alexandra region.

He swims against the tide as noted by his North South trellis planting system whilst everyone else is east west in the Gibbston Valley. He was the original wine maker at the Gibbston Valley winery and has done vintages in Oregon.

Waitaki holds a special place for him as his birthplace. This maritime influenced region of North Otago is producing elegant wines. The limestone and alluvial soils make for arduous work from the vine but the slow ripening period sees fruit hanging until late April and early May. Fruit and Acid characteristics abound.

I first met Grant in NZ 4 years ago. A pure delight. Recently I hosted a dinner with his marketing manager, Hollis Giddens. This well versed immaculately dressed wine siren is an asset to the Valli Team. The Mississippi twang is a delight to listen to.

The wines shone bright educating the guest about the fascinating world of terroir. Whilst polarising the room on a favourite, all agreed that they are exquisite wines made with attitude, elegance and sense of place. The restaurant, Harrys of Buderim, provided 5 courses of sensational food.

Wines Tasted

2012 Valli Alexandra Riesling- Light straw colours with hints of green. The nose has delicate lime citrus notes with some floral and minerality. The palate delights with anterior tightly wound fruit flavours that develop as the wine warms up. Acidity is wonderfully rampant with almost no residual sugar. Cellar for 6 years. Had with chilled leek and CEAS spanner crab soup.

2011 Valli Waitaki Pinot Noir- attractive dusky red colours. The bouquet exudes red well ripened fruits. Brambly nuances flitter with some oak characteristics. The palate at first feels over ripe but within 10 minutes it morphs into a complex integrated wine. Cellar for 10 years. Drank with fried sheep's cheese fennel salad.

2011 Valli Gibbston Valley Pinot Noir- A brighter red colour. The aromas of delicate red fruits and cherries are typical of the region. Twiggy funky spicy aromas develop. The palate is silky but then develops a peak of acid and structure. Cellar 10 years. Drank with Hervey Bay Scallops and pork belly on mustard mash.

2011 Valli Bannock burn Pinot Noir- Deep red to purple. Big complex red to plummy fruits delight. Hints of Asian spice, tarragon and even leathery notes appear. Somewhat typical of the big Pinot Noir of Central Otago but balanced by Grant Taylor's ability to produce the 'iron fist in a velvet glove'. The palate is sweeping with fruit structure and desirability. Cellar 12 years. Drank with Caramelised duck a la orange.

Dr Plonk.

DR DOROTHY HERBERT ….. 1923 – 2014.

Pioneer Woman Pilot, RFDS, Past Member SCLMA, Sunshine Coast General Practitioner.

Dr Dorothy Herbert confessed she had only two dreams: to be a doctor and to fly. Her aspiration to be a pilot started at age 13 when she was inspired by a picture of Jean Batten in a white flying suit, helmet and goggles. (Jean Batten at age 25 in 1936 made the first direct flight from England to NZ.)

Dorothy studied and worked as a biochemist and put aside 3 pounds a fortnight from her wages for flying lessons. She had wanted to do medicine as a career, but was dissuaded from this course by her father who felt she would "just get married and have babies". (She did neither).

She went to England and served in the RAF Volunteer Reserves and it was a great disappointment that the war ended before she qualified for her full RAF wings. She dearly wanted to fly a Spitfire.

She was enticed back to Australia by her father who now promised to pay for her to study medicine. Combining her two passions she did locum work for the RFDS in Charleville, and spent 20 years there as a GP. To attend emergencies on remote stations, visit outlying communities and help the local surgeon reach his patients, she bought her first aircraft, a Cessna 182 VH-WAM in 1963.

Soon she and WAM were a familiar sight in the outback, attending births and deaths, tending the sick and transporting the desperately ill. She was involved in many life-or-death events, treating critically ill patients and bringing them safely to hospital.

She subsequently owned a Piper Comanche and became well known for her flying menagerie – two dogs, a cat and a parrot accompanied her on her flights. Her dog Kendi built up 1500 flying hours.

"If I saw the Russian ballet was playing in Adelaide, I would hop into my Comanche and be there in three and a half hours" she said. "I would come back feeling on a high for some time."

Other adventurous expeditions included flying to Bali with another woman pilot and a male steward in tow. Hers was the first light aircraft to land on the new international airport at Denpassar in 1971. She flew herself around Australia to many of the AWPA conferences.

Dorothy was thrilled to achieve her silver C certificate in gliding and became CFI at the Charleville Soaring Club. But in 1981 a freak squall tossed a glider on top of her, crushing her chest and spine. She spent many months in hospital and moved to the Sunshine Coast, practising as a GP there for 15 years.

A foundation member of the Australian Women Pilots' Association, Dorothy finally gave up practising medicine and flying in 1996, when she flew a Skyfox to the AWPA conference in Longreach at the age of 75. Having clocked up about 2200 powered hours and 300 hours gliding , she had been a pilot for 50 years. She was invited up to the flight deck of the Concorde flying from New York to London.

In 1997, she was granted an Honorary Life Membership of AMSANZ (now ASAM) and retired as a DAME after 35 years. She received an Order of Australia in 1999 for her service to rural medicine through RFDS and to aviation through AWPA.

This article was written by Dr Heather Parker for the Australasian Society of Aerospace Medicine.

Parts of the original article have been sourced from: "Dames of the Air" in Sunshine Coast Daily 1997 by Kitty Vivekananda, "Coast's High Flying Doctors" in Courier Mail Extra 1997 by Frances Whiting and the website "It's An Honour" www.itsanhonour.gov.au Collection: Powerhouse Museum, Sydney. Photo: Sue Stafford

A Mystery called Machu Picchu ...

Azure blue skies and emerald green hills, the mysterious ruins of an ancient civilization, pristine, serene and awe-inspiring – it is no surprise why Machu Picchu is counted among the new Seven Wonders of the World!

For the Active

If trekking and a holiday off the beaten track are your idea of a break, Machu Picchu should rank high on the list of must visit destinations. Be ready to experience a host of sensations as you make this breath-taking 99km journey from Cusco to the engineering marvel that awaits you at Machu Picchu.

A train journey combined with the entry fee to the ruins will set you back by a minimum of 150$ so those who do not mind a workout and have sufficient days in hand will find roughing it out and battling the elements worth their while, just to be able to experience the majesty of lush green alpine jungle landscape, a jaw dropping night sky with more stars than you ever saw in your lifetime and the mesmerizing historical architecture.

Soak in the extraordinary views of Machu Picchu as you walk the **Inca trail**, which Hiram Bingham took in 1911 to track down a hidden Inca city.

For Seekers and Admirers

If you itch to know why Machu Picchu was built and that too at a citadel with the most awe inspiring location that is almost fit for the gods, check out the practically deserted but spectacular **Museo de Sitio Manuel Chávez Ballón**, tucked at the end of a dirt road, about a 30-minute walk from the town of Aguas Calientes and situated near the base of Machu Picchu.

Twice as tall and located at the opposite end of the site, the **Huayna Picchu summit** offers bird's eye views of the extraordinary architecture as well as the fast flowing Urubamba River, which coils around the site like a white snake.

Temple of Condor is a historical attraction, named on a carved head of a condor with widely spread wings.

This is just to name a few as Machu Picchu offers plenty to see and admire the cultural heritage!

We have developed the Itinerary keeping the top attractions in Machu Picchu:

Hiking and Hiking!

Even though it looks hard to climb, it is not really, believe us. Our experts take you to one of the famous climb of 90 minutes to the mountain of Wayna for you to enjoy the breathtaking views to capture from your Canon or Nikon lens. Also, the 4 day Inca Trail will satiate the hiker in you as you walk amid the gorgeous mountains, serene rivers, and forests hugged with clouds, only makes the hiking experience truly memorable!

Sacred Valley of Cusco

Our guides take you to Cusco and its popular sacred valley. Explore the Pisac and Moray ruins, to admire its cultural heritage. Now, we have access to Huchuy Qosco, a local village, which was previously bypassed for travelers.

Enjoy this hidden gem with us and make the most of your Machu Picchu holidays!

Cheryl Ryan www.123Travelconferences.com.au

SCLMA 'CHRISTMAS IN JULY'
PELICAN WATERS GOLF RESORT - 19 JULY 2014

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

MEMBERSHIP APPLICATION

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

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

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

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

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

A TAX RECEIPT WILL BE SENT FOR YOUR RECORDS.

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

SCLMA PO BOX 549 COTTON TREE 4558

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

The Sunshine Coast Local Medical Association has Public Liability Insurance

SUNSHINE COAST LOCAL MEDICAL ASSOCIATION
MANAGEMENT COMMITTEE MEETING
THURSDAY 24 JULY 2014
Maroochydore Surf Club Function Room, Maroochydore
MINUTES
(Accepted at Committee meeting 28 August 2014)

The meeting opened 1810.

Attendance: Drs Di Minuskin, Rob Ingham, Scott Masters, Mason Stevenson, Marcel Knesl, Jeremy Long, Denise Ladwig, Fiona McGrath, Kirsten Hoyle, Nigel Sommerfeld, Scott Phipps, Peter Dobson and Carol Hawkins (Observer)

Apologies: Drs Peter Ruscoe, Byron Oram and Wayne Herdy

Business arising from Minutes:

- Response from the DG GP lead clinics as raising a co-payment. GP lead clinics, Di will elaborate in her President's report.

President's Report: Dr Di Minuskin.

1. Requested meetings with local Federal members to discuss the impact of proposed Federal budget changes on regional Medical services in the Sunshine Coast community. Clive Palmer declined. We are still awaiting a response from the Hon Mal Brough's office.
2. Rob Ingham and I met with Sandra Peters to discuss issues surrounding the off site fracture clinics to be run by OCHRE Health in Sippy Downs (Super Clinic). We expressed concern regarding the EOI process, as it was confirmed that Medicare Local was responsible for distributing an 'expressions of interest' email sent to 103 practices but it was confirmed only 46 of the emails has been opened. I personally spoke with 7 mainstream practices in Caloundra but not one of the doctors received the 'expressions of interest' email from Medicare Local. It was expressed that GP Medical Local emails were not high priority in GP practices. This important email contained important information which was lost in 'white noise'. We highlighted the fact that Medicare Local emails were not accessed by all practices in the region and it was less than an ideal way to distribute this important information and there is a need for better communications so GP Practices know what is being communicated to them. Sandra was disappointed that it had not been recognised and only opened by 46 practices and said that the email was headed for the attention Practice Managers. It was noted that no knowledge of the Fracture Clinic or the 'expression of interest' were known - by Dr Mason Stevenson who is a board member.
3. Further discussion is needed to be presented in sessions on how, when, and where and that not enough GPs are in consultation. This lack of good communication has great impact on GPs who are written out of a possible lucrative proposition. How can you design a system without GP input to make it viable. This is a statewide initiative which is only an interim arrangement. Contract with OCHRE has been signed.
4. We discussed the importance of the HHS having an up-to-date contact list for ALL GPs and to avoid using a 'third party' which does not reach all practices. Invitation to talk about the shared management of patients to the LMA Members.

Vice President's Report : Dr Rob Ingham

- Co-Payments - Rebate deletion 'Oz Dr' Mr Abbott said 'he thought most GPs were in agreement to a co-payment."
- GP Practices would be taking more of a back seat if this decision comes to fruition.
- Basic Medical care will be unaffordable for some patients.
- AMA have been invited to help rewrite the scheme - they believe the Co-payment should be deleted,
- There should be more balance of GP involvement in this discussion to uphold the quality of General Practice
- It was suggested the LMA write to Brian Owler concerning these issues.
- AMA Model would oppose any lessening of the Medicare rebate to support General Practice.

Secretary's Report: Dr Wayne Herdy - Apology

Correspondence In:
- Paddy Guildford – Doctor's Finance Facility Information
- Clive Palmer Office – unable to meet request for meeting
- Helen Squires – re request for Di & Rob to meet

Correspondence Out:
- Clive Palmer – request for meeting to discuss impact of the Federal Govt changes to Medicare
- Mal Brough – as above.

Business arising from Correspondence:
- Paddy Guildford's email to be resent to the committee for further discussion.

Treasurer's Report : Dr Peter Ruscoe - Apology

SCLMA MANAGEMENT COMMITTEE MEETING
THURSDAY 24 JULY 2014
Maroochydore Surf Club Function Room, Maroochydore
MINUTES /cont:

Accounts to be paid:
- Australia Post – Account June 2014
- Mullins IT - hosting
- Snap Printing – July newsletter
- C Bourke – website updates
- Jo Bourke – July 2014 newsletter
- Carol Hawkins July Assistant Secretariat

(b) Membership Report.
- Dr Tim Nathan, Urology - member application was signed by committee
- Dr David Chin (Plastic & Reconstructive surgery) - member application was signed

AMAQ Councillor's Report: Dr Wayne Herdy – Apology

Meetings Convenor Report: Dr Scott Masters – no report

Focus Health Network Report: Dr Scott Phipps
- Nothing to report this meeting.

Hospital Liaison Report: Dr Jeremy Long
Nothing to report

Medicare Local Report:
- The Medicare Local is in limbo ending July 2015 as the primary network for General Practice.
- Not sure how many will be able to stay - 5 or 6 - or only 2; one urban and one rural Medical Local - only the other hand there could be a discussion to keep 10?
- Department of Health and Ageing - No ageing attached to this portfolio now.
- Tendering Document completed by Dec and decision by Feb 2015
- Very rushed.

General Business:
- Rob and Di will draft up a invitation to Kevin Hegarty and Piotr Swierkowski to speak at the next SCLMA meeting on the 28 August 2014

Meeting Close 1900

Next meeting: Thursday 28 August 2014, Maroochy Surf Club Function Room.

Carol Hawkins (filling in for Dr Wayne Herdy, Honorary 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 .....

PRIZE WINNING IDIOTS OF 2013

Number One

"I am a medical student currently doing a rotation in toxicology at the poison control centre in Brisbane. Today, this woman called in very upset because she caught her little daughter eating ants. I quickly reassured her that the ants are not harmful and there would be no need to bring her daughter into the hospital. She calmed down and, at the end of the conversation, happened to mention that she had given her daughter some ant poison to eat in order to kill the ants. I told her that she better bring her daughter into the emergency room right away".

Number Two

Some Boeing employees on the airfield in Sydney decided to steal a life raft from one of the 747s. They were successful in getting it out of the plane and home. Shortly after they took it for a float on the river, they noticed a Westpac Rescue Helicopter coming towards them. It turned out that the chopper was homing in on the emergency locator beacon that activated when the raft was inflated. They are no longer employed at Boeing.

Number Three

A man, wanting to rob a Bank of Queensland, walked into the Branch and wrote 'Put all ya muny in this beeg.' While standing in line, waiting to give his note to the teller, he began to worry that someone had seen him write the note and might call the police before he reached the teller's window. So he left the Bank and crossed the street to the NAB Bank. After waiting a few minutes in line, he handed his note to the teller. She read it and, surmising from his spelling errors that he wasn't the brightest light in the Harbour, told him that she could not accept his stickup note because it was written on a Bank of Queensland deposit slip and that he would either have to fill out a NAB deposit slip or go back to Bank of Queensland. Looking somewhat defeated, the man said, 'OK' and left.

He was arrested a few minutes later, as he was waiting in line back at the Bank of Queensland.
Happened in Brisbane.

Number Four

A guy walked into a little corner store in Cairns with a shotgun and demanded all of the cash from the cash drawer. After the cashier put the cash in a bag, the robber saw a bottle of Scotch that he wanted behind the counter on the shelf. He told the cashier to put it in the bag as well, but the cashier refused and said, 'Because I don't believe you are over 21.'

The robber said he was, but the clerk still refused to give it to him because she didn't believe him.

At this point, the robber took his driver's licence out of his wallet and gave it to the clerk.

The clerk looked it over and agreed that the man was in fact over 21 and she put the Scotch in the bag. The robber then ran from the store with his loot.

The cashier promptly called the police and gave the name and address of the robber that she got off the licence. They arrested the robber two hours later.

Number Five

A pair of robbers entered a record shop nervously waving revolvers. The first one shouted, 'Nobody move!' When his partner moved, the startled first bandit shot him.
Happened in Adelaide.

Number Six .

A guy wanted some beer pretty badly. He decided that he'd just throw a brick through a liquor store window, grab some booze, and run. So he lifted the brick and heaved it over his head at the window. The brick bounced back knocking him unconscious. It seems the liquor store window was made of Flexi-Glass. The whole event was caught on videotape.
Happened in Perth WA.

Number Seven

"My daughter went to a local McDonalds and ordered a burger. She asked the person behind the counter for 'minimal lettuce.' He said was sorry, but they only had iceberg."
Happened in Surfer's Paradise.

Number Eight

"I was at the airport, checking in at the gate when an airport employee asked, "Has anyone put anything in your baggage without your knowledge?" To which I replied, "If it was without my knowledge, how would I know?" He smiled knowingly and nodded. "That's why we ask."
Happened in Melbourne.

Number Nine

"When my husband and I arrived at a car dealers to pick up our car, we were told the keys had been locked in it. We went to the service department and found a mechanic working feverishly to unlock the driver's side door. As I watched from the passenger side, I instinctively tried the door handle and discovered that it was unlocked.

'Hey,' I announced to the technician, 'it's open!'

His reply, 'I know - I already done that side.'"

Happened at the FORD dealership in Dubbo

CLASSIFIEDS

CHANGE OF ADDRESS - DR DAVID COLLEDGE, SURGEON, GENERAL / COLORECTAL.

- Dr Colledge has moved his consulting rooms to Suite 9B, Nucleus Medical Suites, 23 Elsa Wilson Drive, Buderim.
- Dr Colledge is continuing to operate at the Sunshine Coast Private Hospital Buderim and Nambour Selangor Private Hospital.

Ph: 5478 1449 Fax: 5444 2740

September 2014

ORTHOPAEDIC SURGEON – DR LUKE MCDERMOTT – RELOCATION

- Dr Luke McDermott wishes to advise he has relocated from Suite 18 to Suite 8, Sunshine Coast University Private Hospital, 3 Doherty Street, Birtinya, Qld 4575.

All Appointments: (07) 5438 8900, Fax: (07) 5302 6818.

September 2014

DR AJAY VERMA - CONSULTANT SPECIALIST PHYSICIAN,

- Has credentialling and admitting rights for Sunshine Coast University Private Hospital, Birtinya, from 1st September 2014. Now accepting new general medicine private inpatients at SCUPH.
- Consulting Rooms - Nucleus Medical Centre,
- Suite 8, Level 2, Sunshine Coast Private Hospital, Buderim 4556

Ph: 07 5479 6886 Fax: 07 5479 6889
For Inpatient referrals - Fax 07 5302 6660

September 2014

MONTHLY PAEDIATRIC DERMATOLOGY CLINIC - NAMBOUR GENERAL HOSPITAL

- Starting September/October - Nambour Paediatric Outpatients – **Dr Leith Banney Contact 5370 3235.**

August 2014

LIFETIME HEALTH MEDICAL CENTRE – SEEKING GENERAL PRACTITIONER VR (F/T OR P/T)

- This is a newly established Practice in Wurtulla;
- Modern medical practice with excellent facilities in a well established residential area. The GP can choose to run as own business or work as an employed GP.
- Non corporate, excellent % of fees; Mixed billing
- Full nursing support with fully equipped treatment room
- Not DWS

For further information contact Julianna on 0403 259 156 or email julianna@pacific.net.au

August 2014

SUNSHINE COAST PAEDIATRICS IS MOVING

- Drs Paxton, Scorer, and Morosini are pleased to announce that from 11th August 2014 their consulting is from Suite 9a, Nucleus Medical Suites, Building A The Sunshine Coast Private Hospital, 23 Elsa Wilson Drive, Buderim, Qld, 4556
- Existing Rooms at Buderim and Nambour will close

All Appointments - Ph: 5444 5177 Fax: 5444 5322

August 2014

DR SONIA SHAH, FRACP. – GENERAL PAEDIATRICIAN

- SUNSHINE COAST PAEDIATRICS is very happy to announce that Dr Sonia Shah will be joining the Practice from 25th August 2014.
- Dr Shah started her training in the UK, completing this at several Queensland training hospitals this year. She will be providing Neonatal care at The Sunshine Coast Private Hospital, Buderim and Consulting at our new Rooms at 9a Nucleus Medical Suites, at the same Hospital.
- Dr Shah is happy to consult in all areas of General Paediatrics. She has special interests in Neonatal Care, Developmental and Behavioural Problems as well as Respiratory and Endocrinological Issues

Accepting Referrals Now Ph: 07 5444 5177
Fax: 07 5444 5322

August 2014

PROFESSIONAL OFFICE IN "ESPLANADE & SECOND", COTTON TREE ESPLANADE - FOR LEASE OR SALE.

- 76 sq m, 2nd floor, river views. Currently fitted out & occupied by Sunshine Coast Haematology & Oncology Clinic, available October.

Contact: david.leslie@optusnet.com.au or 0418 150 991 / 0419 663 550

August 2014

DR JEFF TARR OBSTETRICIAN & GYNECOLOGIST NEW CLINIC

- Ochre Health Medical Centre
- 9 Ochre Way Sippy Downs 4556

All Appointments: Ph: 5476 6356 Fax: 5476 5849
Email: drejtarr2@westnet.com.au
Website: www.drtarr.com.au

July 2014

PSYCHIATRIST - DR MICHELLE LIEN CHANGE OF ADDRESS

- Dr Michelle Lien is a general adult psychiatrist who provides specialist consultation on a wide range of psychiatric conditions including mood, anxiety and psychotic disorders for patients aged eighteen and above. New referrals welcomed.
- Dr Lien has relocated to The Sunshine Coast Private Hospital - Cooinda Clinic
- 12 Elsa Wilson Drive Buderim QLD 4556

Phone: 07 5452 0506 Fax: 07 5444 7299
cooinda.clinic@uchealth.com.au

July 2014

RETIREMENT

- Dr Richard John is pleased to anounce his retirement. If notes/summaries of my former patients are required by any of my colleagues, please fax requests to:
  Fax: 5442 3209 (Ph: 5442 1740)

I'll endeavour to reply ASAP. There may be delays due to our travels.

July 2014

The Sunshine Coast Falcons ...

are looking for sports minded GPs who would like to assist at home games for the 2015 season. This will be a very exciting year for the Falcons as they have just signed a 3 year contract with the Melbourne Storm as their feeder club. All queries, please call Dr Steven Lawrie at Sunshine Coast Orthopaedic Clinic

Ph: 5493 3994

August 2014

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 CLINICAL MEETING - 28 AUGUST 2014

Maroochy Surf Club Function Room, Maroochydore
Dr Jenny Grew, QML Pathology - 'Preventing Cervical Cancer'
Clinical cases to presented by Dr Kelvin Larwood and Dr Karien Treurnicht
Also - Mr Kevin Hegarty and Dr Piotr Swierkowski - 'The Hospital/Primary Care Interface'
Sponsor - QML Pathology

Dr Jerome Lai with Dr Kelvin Larwood (Presenter)

Dr Sandra Peters, Dr Rob Ingham and Dr Di Minuskin (SCLMA President)

Left: Presenter Dr Jenny Grew, Pathologist, QML Pathology with Carlene Palmer, QML Pathology Liaison

Dr Stacey Wirth, Dr Karien Treurnicht (Presenter) with Dr John Adkins

Kevin Hegarty, Health Service Chief Executive, Jo Bourke and Dr Piotr Swierkowski

Dr Kevin Barker, Dr Jeff Tarr and Dr James Moir