NEWSLETTER
May 2016

SCLMA President's Message .....

Dr Di Minuskin

The federal budget bought very little good news. The extension of the rebate freeze until mid 2020 is a particularly devastating blow to those offering a "bulk billed" service to low income earners or pensioners. The impact of this has been discussed at length on medical blogs and in tearooms across the country. I will not dwell on this. Suffice it to say, that in order to maintain the standard of care that our patients deserve, generate enough income to cover practice costs and sustain a wage commensurate with professional status and training, "bulk billing" rates must fall. The federal election has been set for early July. Electoral promises will be viewed with a renewed sense of cynicism. The "temporary" rebate freeze now appears to be a firm policy for cost saving, and likely to remain in place as long as practices are prepared to absorb the losses.

I am currently in the USA seeing family, though will be back "Down Under" well and truly before this report is published. Arizona continues to impress with its desert charm and rugged beauty. The cacti are all bursting with flower, surprisingly fragile and fleeting bursts of colour. Mr M has had a less enjoyable interaction with the cacti on the golf course. There is a variety called Cholla (CHOY-uh) that is particularly nasty. The experienced golfers carry pliers in their golf bags to remove the thorns! A good incentive to stay on the fairway I would think. The back garden is a haven for quail, humming birds and road runners. It hasn't all been holidays though. I've still managed to teleconference into some meetings back in Australia and those darn emails just keep on coming! This leads me on to an interesting talk I attended last week. Professor Taylor Riall is a young woman with an impressive list of appointments. A graduate of John Hopkins, she is Chief, Division of General Surgery and Surgical Oncology and Vice Chair for Quality and Performance at Banner University Hospital. She discussed the importance of "wellness" and life balance and how it can have significant impact on professional roles. A more in depth assessment of "Stop and smell the roses" and a timely reminder of the stress levels encountered throughout the medical profession.

I certainly did not plan it, but the timing of this trip has managed to ensure I will experience at least some of both the American and Australian election campaigns. It is evident that the USA campaigns are a great deal more theatrical and pervasive than ours. I can't wait to get home to the Sunshine Coast where at least you hit the mute button to have some peace and quiet.

On a happy note, your committee has decided on a date and venue for our annual function. I know how much this event is enjoyed by those who attend. It is a great opportunity to catch up with your friends, enjoy some great food and flush out the musical talent amongst our colleagues. Your ticket remains heavily subsided by the SCLMA, but this year there is a small ticket price for all attendees. This will allow us to keep the annual membership fees low, provide free monthly meetings, continue the Sunshine Coast University bursary, and support charities within our community. I hope to see many of you there. Come along and be part of a wonderful evening.

Di Minuskin

SCLMA Social Function Sat 13 August, Surfair, Marcoola. Invites on the way!!

The SCLMA thanks Sullivan Nicolaides Pathology for the distribution of the monthly newsletter of the Sunshine Coast Local Medical Association.

Sullivan Nicolaides PATHOLOGY
Quality is in our DNA

CONTACTS:

President and	Dr Di Minuskin Ph: 5491 2911
Vice President & AMAQ Councillor	Dr Wayne Herdy Ph: 54791 5666
Secretary:	Dr Jenny Grew Ph: 5441 0200
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 Mason Stevenson Dr Nigel Sommerfeld Dr Mark De Wet

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
Marcel.knesl@roc.team

JUNE 2016 NEWSLETTER Deadline Date will be FRIDAY 17 JUNE 2016

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 more than 1,000 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.

Welcome to the May edition of the newsletter.

First and foremost, I must ask you to diarize this year's SCLMA mid-winter Christmas function. Saturday 13th August, Surfair on Marcoola Beach- The Views, 923 David Low Way, Marcoola.

*These functions are always well attended and a wonderful way to catch up with colleagues in a non-educational environment. The cost of the tickets is heavily subsidized through the LMA. The cost of tickets this year will be $55 for **both** members and partners. The cuisine is always varied and very good and the evening's entertainment includes a local well known band.*

SCUH update included the tradies going on strike on the 12th May. Of the 900 or so tradies on site about 135 union members blocked the gates. Fortunately, the opening of SCUH had already been postponed till April 2017 so I assume time lines were not affected.

This month's AMA Councilor's column pretty much make my column redundant, haha. Wayne tears through the election campaign moving through the Federal budget to Medicare benefits, to negative gearing like a man possessed. A definite read in this month's newsletter.

Di follows with up her Presidents report and Michael is once again on song with his wine blitz.

Clive is absent but for good reason, so I refer you to the weekend AFR for the motoring column. This weekend it's the Audi's that impress. As one of my junior colleagues always jokes, if you really want to feel poor read the weekend AFR.
SCR's case this month highlights the Iliotibial Band Syndrome. A very important sporting injury.

So we enter another week on the campaign trail. Do you go with Turnbull or Shorten? A tough ask but one with very significant consequences. On the Sunshine Coast I do feel that we are a bit isolated from the "real" Australia, a cosmopolitan, multiethnic, diverse society. More on this topic next month.

Have a good month and see you at the next LMA evening.

Marcel Knesl

Marcel.knesl@roc.team

HIGHLIGHTS in this issue:

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

THURSDAY 23 JUNE 2016

Speaker: Dr Steven Kypraios, clinical and interventional cardiologist, Sunshine Coast Cardiology
Topic: ***TBA***
Venue: Maroochydore Surf Club

THURSDAY 28 JULY 2016

Speakers: Dr James Askew
Dr Garth McLeod
Topic: New Bariatric service - 'Sunshine Coast Weightloss Solutions"
Venue: Maroochydore Surf Club

THURSDAY 25 AUGUST 2016 (includes Annual General Meeting)

Speaker: Dr David McIntosh
Sponsor: Attune Hearing
Venue: Maroochydore Surf Club

ENQUIRIES:

Jo Bourke

Ph: 5479 3979 (M) 0407 037 112

Email: jobo@squirrel.com.au

Clinical meetings are for current SCLMA members.

New members are welcome to join on the night.

Membership Applications are available at each meeting, in the newsletter and the SCLMA website.

Website: www.sclma.com.au

Noosa Hospital nurse wins Qld Graduate Award of Excellence

Nursing staff at Noosa Hospital have scooped the pool at the inaugural Queensland Ramsay Education Awards held on Friday evening in Brisbane.

Enrolled Nurse Linzie Robinson won the Graduate Award of Excellence and Enrolled Nurse Karen Habben was a finalist in the Preceptor of the Year Award.

Judy Beazley, Director of Clinical Services at Noosa Hospital said Linzie's performance as a graduate has been exemplary.

"From the outset she has demonstrated the Ramsay Way values – caring, progressive, enjoys her work and uses a positive spirit to succeed. Her achievement is all the more remarkable because there were a number of Registered Nurses and Midwives nominated and yet it was Linzie's achievements that captured the judge's attention," she said.

"We couldn't be happier and prouder of Linzie for her Graduate Award win and overall, to have two outstanding Enrolled Nurses as representatives of Noosa Hospital," Judy said.

The inaugural Queensland Ramsay Education Awards are one of the highlights of the nursing and midwifery calendar, timed to coincide with International Nurses and Midwives Week.

"The awards give participants the opportunity to be recognised and rewarded for their contribution to the nursing profession and to identify individuals who are acknowledged by their peers and their patients as being outstanding." she said.

Graduate winner, Linzie, said it was an honour to receive the award, made possible by the positive and encouraging mentors at the hospital that improved her performance, together with the great team she worked with.

"I'm thrilled, and it's given me even more motivation to be the best nurse that I can be," she said.

(Left to right) -Noosa team ...

Joanne Fahey, Staff Development Manager

Judy Beazley, Director Clinical Services

Karen Habben, Enrolled Nurse

Linzie Robinson, EN, Graduate Award for Excellence winner

Karen Johnson, Nurse Unit Manager

Michelle Venter, Nurse Unit Manager

HEALTH SERVICE LINK - May 2016

Kevin Hegarty

This month in a major change from the usual localised focus of my column, I would like to share with you the details of the recently announced state level plan '*My health, Queensland's future: Advancing Health 2026'.*

The plan was developed through a formal consultative process, including a major workshop. This process created a vision statement that informed the development of the plan. *'By 2026 Queenslanders will be among the healthiest people in the world'.*

The plan has five principles, sustainability, compassion, inclusion, excellence and empowerment. These are supported by four clear directions: Promoting wellbeing, Delivering health care, Connecting healthcare and Pursuing innovation. Each of these directions have their own measures for success.

It recognises that health is a shared responsibility – the plan promotes health as "*everyone's business*" – *every level of government, every government agency, every employer, every community and every individual has an important role in contributing to our health and wellbeing.*

There is also a clearer focus on *consumers as partners, not just passengers*, with patients increasingly being treated in the comfort of the own homes, in familiar surroundings, closer to their support networks, rather than in hospital.

Under the plan, consumers will be encouraged to be a driver of their own healthcare. The active involvement of consumers individually and collectively through networks is now standard in Queensland's health system. The Sunshine Coast Hospital and Health Service has formalised consumer engagement by the creation of a Consumer Advisory Group. This group is supported by a range of other consumer groups and direct individual consumer involvement in service and policy development.

The practical approach of the plan is evidenced in the measures that have been chosen to assess its effectiveness in the 20 year period that the plan seeks to have effect. The plan can be found at the following link:

https://www.health.qld.gov.au/publications/portal/health-strategies/vision-strat-healthy-qld.pdf

Regards

Kev Hegarty

Kevin.Hegarty@health.qld.gov.au

SCLMA CHRISTMAS in AUGUST 2016

DATE: SATURDAY, 13 AUGUST

VENUE: SURFAIR, MARCOOLA

Cost: $55 each for members & partners

Cocktails, 3 course meal, alcohol package.

Guaranteed entertainment from Santa and the M7 Band!

Dr Chris Zappala

Dear members,

Debates about the appropriateness and growing costs of health are guaranteed to evoke emotive, polemical rhetoric and ideological arguments.

Of course, sectional / tribal interests pervade, which compounds the confusion. It is into this fracas that we venture whenever the profession tries to have a sensible discussion around MBS rebates and health care funding. We also need to remember it is a profession-wide issue and not just a general practice issue – although they are more exposed.

The announcement by the Commonwealth Government that the freeze on MBS rebates will continue until 2020 is disheartening for us all. The AMA has strenuously and correctly argued for the MBS rebates to be indexed appropriately and to truly reflect costs of practice so that patients are not left significantly out of pocket and doctors are not forced to perpetually reduce margins. This fight will go on. It is, however, critical to observe that constraint on MBS rebates is a bipartisan objective.

Moreover, and perhaps most tellingly, MBS rebates have never really been properly indexed or reflected the costs of practice since they were introduced in 1984 (to reflect average prices in the 1970s!). Patients (and doctors who accept bulk-billing) have progressively slipped further and further behind over many years. We should not be surprised by the continuation of the rebate freeze, or woefully inferior indexation even if it were to be adjusted, because that has always been the case.

The MBS rebate freeze is a policy designed to reduce government costs and ultimately shift a greater portion of the financial burden to doctors, patients or third parties such as health funds. Governments seem to have developed the standard strategy of blaming doctors for all rising health care costs through exorbitant fees, over-servicing, errors and so on. So are costs becoming unmanageable? In short – No! Health care costs as a proportion of GDP remain static at 9.8 per cent and costs have grown *below* expectation recently at approximately three per cent per year (it was projected to be approximately five per cent).

The Commonwealth Government is paying less in total (15.97 per cent of the total budget down from 18.09 per cent of total budget between 2015-16 and 2006-7) and the proportion of total health funding by private health insurers has remained static. Total payments by private health insurance companies have grown by 7.1 per cent, but premium revenue increased by 7.3 per cent for the 2015 financial year. In addition, private health insurance (PHI) management costs reduced from 10.5 per cent in 2008 to 8.5 per cent in 2014 – so the private hospital sector is becoming more efficient and no less profitable. Where on earth is the crisis?

It is true, however, that patients are paying more. Over the last decade, expenditure by individuals grew by an average of 6.2 per cent per year in real terms, compared with 5.3 per cent for all non-government sources, and grew faster than total health spending. What is less appreciated by the public, and conveniently ignored by policy makers, is that doctors (especially bulk-billing GPs) have also suffered financially as their practice costs have increased but revenue remained static, courtesy of the inadequate MBS schedule.

I find it amazing that bulk-billing rates in general practice have not reduced since the MBS rebate freeze was introduced (still in the 80s%). This patient rebate – designed to be the least the Government of the time can possibly get away with offering – was never designed to be a sole payment for services to doctors. It's a complete travesty that some colleagues, therefore, feel compelled that they must accept this arbitrary amount dictated by the Government. It's plainly not just or appropriate. As a profession is there something we can do to unshackle our colleagues and free us all from the whimsical dictates of successive Governments? Maybe…

While continuing to argue for some increase in the rebate to benefit our patients, perhaps we should draw a line in the sand and finally accept bulk-billing is untenable and not conducive to high quality, safe practice (bear in mind complaints to the OHO are inexorably increasing). We should allow patients to pay just the gap when seeing a GP if desired – this should be an election issue too. The bulk-billing incentive needs to be built permanently into the rebate rate so patients who do pay a gap are not disproportionately disadvantaged. Let's also investigate chronic disease models of care which allow patients to claim some items through their private health insurance – especially if it can be shown this is keeping patients out of hospital and

Dr Chris Zappala / cont ...

within the care of a familiar general practitioner who is no longer tyrannized by enervating bulk-billing. We need to gladly accept that such reforms will also drive quality of care improvements and disadvantage doctors offering an inferior service.

I think the public is sufficiently primed to understand that the government is trying to reduce health care payments (together with all other payments), that MBS rebates have been inadequate for some time and that a co-payment is the government's ultimate objective. Therefore, the public will understand that paying a gap ultimately derives from government actions. One of the most important roles of the AMA is ensuring patients remain fully aware of this and creating the freedom for all doctors to be able to charge a reasonable fee for their own services – of their own determination. When we argue for a MBS rebate increase it should be on our patient's behalf only, because doctors are all charging what their service is worth.

As I've remarked before, the qualifier for my suggestions is that the vulnerable absolutely need to still be protected. There will still need to be some patients who are bulk-billed (but at the doctor's discretion and to a level that is reasonable) and the continued operation of safety nets remains important. Patients requiring multiple investigations and doctor visits should not face unmanageable health care expenditure – there are many ways to achieve this. The Government should perhaps recall the original laudable intent of the Medicare system in protecting disadvantaged patients and those with complex care requirements and re-focus the system along these lines.

As I write this, I am looking forward to the upcoming AMA Annual National Conference (which may have occurred by the time you read this newsletter). The Annual Conference is a truly unique opportunity to explore the critical issues facing us all and celebrate the achievements of the profession. It also brings a change in Federal AMA leadership who will crucially need to focus on core issues of concern to our profession and also focus on how our Association can work more effectively together to grow members, meet their expectations and advocate for a better health care system for doctors and their patients.

Sincerely,

Dr Chris Zappala,

AMA Queensland President

ACCREDITED EXERCISE PHYSIOLOGY
WHAT ARE THE HEALTH SYSTEM BENEFITS?

DIABETES
- For people with type 2 diabetes receiving an exercise intervention the expected annual saving for the health system expenditure is $5,107 per person annually.
- For people with pre-diabetes receiving an exercise physiology, the expected annual saving in health system expenditure is $1,977 per person annually.

MENTAL HEALTH
- Each case of depression averted through exercise, the expected annual saving in health system expenditure is $10062 per person annually.

CARDIOVASCULAR DISEASE
- The total lifetime burden of disease savings resulting from exercise interventions in people with CHF are estimated to be $11,847 per person annually.

PREVENTION OF CHRONIC DISEASE
- While the focus above is on exercise for management of chronic disease, rather than prevention, epidemiological data show that low exercise capacity is a strong predictor of all-cause mortality, a stronger association than that for smoking, hypertension, hyperlipidaemia and diabetes.

Statistics from the 2015 Deloitte 'Value of Accredited Exercise Physiologists in Australia' analysis.
For a full copy, please contact Brad directly on: Brad@sportsandspinalphysio.com.au

sports & spinal™
sportsandspinalphysio.com.au

Our EP services are FULLY Bulk-Billed!
7 Clinics on the Sunshine Coast:
Buderim | Maroochydore | Nambour
Caloundra | Coolum | Kawana | Sippy Downs

AFFORDABLE, ACCESSIBLE QUALITY DIAGNOSTIC SERVICE

BULK BILLING*

*Same Day appointments available for X-Ray, Ultrasound, CT & Nuclear Medicine***

Queensland Diagnostic Imaging offers Bulk Billing for the following services:

Buderim	Caloundra	Maroochydore	Noosa
12 -14 King Street, Buderim 4556	18 Mayes Avenue	Unit 1, Cnr Horton & Plaza Parades	Noosa Private Hospital Pav A, 111 Goodchap St
Ph: 5444 5877	Ph: 5438 5959	Ph: 5443 8660	Ph: 5430 5200

SCHHS GPLO - MAY 2016 UPDATE

Dr Sandra Peters

Greetings from the GP liaison desk at Nambour Hospital and thanks to the GPs who have corresponded with me this month to highlight some of the gaps in clinical handover of care which have impacted on their patients. These cases help to inform the ongoing discussions between consultants and junior clinicians about the importance of clinical handover and contribute positively to the necessary change in culture to drive further change. Delayed communications between hospital clinicians and GPs is sadly not unique to the Sunshine Coast and at the national conference for GP liaison in March and every Queensland GPLO forum over the past 3 years it has been a point for discussion.

I am pleased to report that when benchmarked against other services SCHHS performs well, but I acknowledge there is still a lot of work to do in this space. Whilst local progress is slow it continues in a forward direction and I thank my colleagues in primary and secondary care for their continued patience and participation.

Smart Referral Solution for GPs:

Currently SCHHS is involved in a proof of concept for a web based smart referral solution for GPs. We would welcome additional participants over the next 4 weeks in order to ascertain whether this enhanced template would be welcomed by GP colleagues. Please call Sandra ASAP for more information on 0427 625 607.

GP Communication Reference Group:

The inaugural SCHHS 'GP Communication Reference Group' meeting was held at Nambour General Hospital on the 3rd May. Several GPs were in attendance and they each had the opportunity to raise concerns and to provide feedback about projects and initiatives currently being proposed within the SCHHS.

All GPs are very welcome to become a member of the reference group. Meetings will be held approximately every 6 weeks and participants will have the choice to either attend in person at the Nambour General Hospital or participate via videoconference (a link will be emailed for ease of access).

Please contact the SCHHS GP Liaison office (SCHHS-GPLOCOMMUNICATION@ health.qld.gov.au) for more information or to advise if you wish to become a member of the GP communication reference group.

Best wishes,

Sandra ***Contact:*** ***0427 625 607*** ***Sandra.peters@health.qld.gov.au***

SCLMA CHRISTMAS in AUGUST 2016

DATE: SATURDAY, 13 AUGUST

VENUE: SURFAIR, MARCOOLA

Cost: $55 each for members & partners

Cocktails, 3 course meal, alcohol package.

Guaranteed entertainment from Santa and the M7 Band!

AMAQ COUNCILLOR REPORT

Dr Wayne Herdy

FEDERAL BUDGET

There are two stand-out health matters in the Federal Budget.

Firstly, the proposal to increase tobacco excise, and increase the cost of a pack of cigarettes to $40 by 2020, will have to bring health benefits. But the story is not so simple.

1. The most hardened of addicts will feel the price signal and reduce consumption.
2. But the social cost will include discretionary spending on tobacco instead of on life's essentials. Some parents will have to reduce spending on their children. We GP's already see Mums who complain that they cannot pay for their child's prescription while they have a cigarette pack clearly visible in their handbag. Mums will be prepared to spend less on food to maintain their tobacco consumption.
3. We might not have a lot of effect on the behaviour of established addicts, but ultimately the health budget benefit will be fewer young kids taking up smoking.
4. A century ago, America proved that prohibition doesn't work. It just drove the alcohol problem underground and made criminals wealthy. Taxing tobacco to the hilt will have a similar effect. "Chop-chop", illegal untaxed tobacco, will become more attractive to purchasers and the high excise rate will encourage illegal suppliers attracted by increased potential profits.

Secondly, the announcement that Medicare benefits will be frozen until 2020 has provoked a flurry of opinions from every possible source. Since we will have fixed incomes but ever-increasing costs (staff wages being the largest component), any increase in costs will be a dollar-for-dollar reduction in our take-home pay; every dollar cost increase will reduce our discretionary incomes by one dollar. This insult comes at the end of decades of progressive erosion of Medicare rebates – the annual increase in Medicare rebates has been almost exactly half the increase in CPI almost every year since 1976.

- If, as I believe, doctors are not going to accept a rapid decline in their discretionary incomes, the outcome will inevitably be an equally rapid decline in bulk billing.
- The question will not be one of whether bulk billing declines. It will be a question of how much and how fast. The first casualties in the bulk-billing decline will be patients who don't have Centrelink benefits, but we are still an altruistic profession so many who are financially hard-pressed will still benefit from what is undisguised charity.
- The other question will be – which doctors will blink first? I predict that the corporate will be the first to change their bulk-billing policies. They are already on low margins and have shareholders looking for a return on investments. They are less likely to tolerate an erosion in nett incomes than doctor-owned practices where most are governed by some degree of altruism.
- One thing is certain. Patients who are used to being bulk-billed will flock to emergency departments.
- We will have to be careful as a profession to ensure that the blame lies where it belongs. The government will blame greedy doctors for withdrawing from bulk billing. We must keep our patients on side by ensuring that, from the very beginning, they know that financial reality means that we cannot universally discount the price of our services.

NEGATIVE GEARING. A PERSONAL PERSPECTIVE.

Like most other professionals, I have one or two investments other than my superannuation. Some of my investment portfolio includes rental properties, negatively geared of course. I am not an investment adviser, and to be truthful I have not even been a particularly successful investor, so the opinion that follows should not be accepted as unassailable gospel, and nobody should even accept it as advice. It is a personal opinion, no more. However, I think that the Labor Party's proposal to bring negative gearing to an end is crazy policy, just crazy.

If my negative gearing benefit comes to an end, I as a landlord will adopt the two obvious strategies. (a) I will increase the income side of the ledger by increasing rents as much as the market will bear. (b) I will reduce the debit side of the ledger by reducing my costs - and since most loans are fixed so I can't much alter my borrowing costs, this means spending less on maintenance. The outcome – my tenants will be paying higher rent with falling quality of the property that they rent. And those families who already struggle to make ends meet will find themselves even less competitive in a marketplace that is a cold hard place for those without a good rental record and a guaranteed income (and no kids, no pets, or any of the other negatives that landlords view with distaste).

Dr Wayne Herdy / cont:

The policy is based on a presumption that, by forcing out of the home-buying market the big investors who pay inflated prices to buy rental properties, the result will be a fall in house prices. There are some real problems with that presumption.

Firstly, investors tend to be business-oriented and they buy economical properties at low prices. This contrasts with private buyers who have a tendency to pay high prices because they make their purchase decision emotionally, not just on financial calculations. It is the private buyer, not the investor, who inflates housing prices beyond fiscal reality.

Secondly, only a small proportion of investors who presently have a taste for rental investments will move away from housing investments to alternatives. No matter how you disparage the relatively small returns on housing compared to other traditional investments, nothing beats the long-term security of brick-and-mortar with capital gains that closely parallel CPI variations. For most investors, the benefit of negative gearing is not massive, but is is an incentive to sweeten an investment that doesn't produce the returns of some alternatives.

Thirdly, the price of established residential property is determined mostly by the price of equivalent new property. The cost of a new residence is determined mostly by two factors. (a) The first is the price of vacant land. At least near Australian capital cities, the price of new land is way too high, mostly because governments have been far too slow to allow developers to release new estates, because of ill-conceived town planning restrictions. Developers have been reluctant, in the present market, to develop estates that will not deliver reasonable returns. (b) The second major influence is the cost of building a new home, and most of that cost that is potentially variable is contributed by the very high wages demanded by tradesmen and construction workers. We have an underlying problem in a country that pays a plumber three times what I pay my practice nurse. However, I don't expect to hear the past trade union powerbroker advocating wage contraction to improve housing affordability.

Bill Shorten's rhetoric includes two arguments that don't stand up to scrutiny. One is that he keeps referring to negative-gearing landlords as big investors, while the truth is that most of the investors who will be affected are the hundreds of thousands of Mum-and-Dad small investors trying to put aside something substantial to leave their kids. The second is that he compares us with other OECD countries where negative-gearing is not available. This is true, but if he wants the Labor Party to align with the USA, it is fairer to the little investor to make changes incrementally over a long and gradual process. To make sudden changes to long-established policy that has influenced small investors' strategies for decades is to court disaster.

My bottom line is to reiterate where I started. To abolish negative gearing is crazy policy. *Wayne Herdy.*

VARIETY BASH – AGAIN.

The Variety Bash is a car rally (well, sort of) with a purpose to raise funds for a respected charity.

"Variety , the Children's Charity" has been around for a long time. Check out their history on their website (www.variety.org.au). They started in Chicago when a group of actors, the Variety Club, found an abandoned baby in the Sheridan theatre on Christmas Eve 1928, with a note from the mother begging them to care for her daughter. They named her Catherine Variety Sheridan, and supported the child, who was fostered. The charity was founded. Catherine changed her name to maintain normality, became a nurse and served in Korea and Vietnam. She died in 1994.

Variety the Children's Charity does not give cash handouts, but gives other support to children in need. This includes medical aids for handicapped children or kids with rare disease. It is one of the few charities where most of the money donated actually ends up where it is intended to go, buying stuff needed by disadvantaged kids.

The Variety Bash is an annual event as part of their fund-raising programme. Participants pay all their own costs and are authorized to conduct activities and receive donations on behalf of the charity. The Australian event was established by renowned adventurer Dick Smith 30 years ago (the Bourke to Burketown Bash was in 1985), and has been conducted annually since.

The basis of the event is that all cars have to be at least 30 years old, and not modified for performance. This is not a race, not even really a rally. It is a survival event for the machine and traditionally a whole lot of fun for the participants.

Dr Wayne Herdy is registered to participate in the 2016 Variety Bash. He has bought a 1986 Mercedes Benz 280SE (cost $800!) and his co-driver Keith Beard has been working to get it roadworthied and registered.

The 2016 Bash will start in Warwick on Friday 30th September and finish in Bathurst on Saturday 8th October, the day of the big race.

Dr Herdy is confident that his fellow doctors will find it easy to be generous to the charity. Donations are of course tax deductible. Donations are most easily made via the internet.

To make donations, go to

https://2016varietybash.everydayhero.com/au/wayne

List of medical donors so far:

- Redcliffe LMA 1005
- Sunshine Coast Radiology 750
- Kelly Williams (NAB Health) 200
- Dr Peter Stephenson 105
- Dr Di Minuskin 105
- Dr Larry Gahan 55

CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST PHN REGION

Pattie Hudson, CEO

As part of our ongoing commitment to healthier communities across our region, the PHN is pleased to announce the Healthy Towns community program for 2016 which aims to improve health and happiness in communities within the region. The innovative pilot program, which was launched in April, will support and reward communities for local health promotion projects that focus on creating new connections between people, encourage use of greenspace, and connect people with their local community.

Central Queensland, Wide Bay, Sunshine Coast PHN have collaborated with the University of the Sunshine Coast, Griffith University, Caloundra Community Centre, Sunshine Coast and Noosa Councils to develop a program in which the local community can feel engaged with and proud of. Several sets of funding will be awarded to chosen community organisations, with grants of up to $5000 on offer for those who meet the award criteria.

Since our inception, PHN has been working toward an initiative that will celebrate the great work which is already being done in our communities, contributing to the health and happiness of local people.

Research shows that when people feel connected to each other and to their local community they will feel happier and therefore healthier. Small local community groups are the best vehicle for achieving this outcome.

We have to remember that health affects every aspect of our lives – programs like this endorse and reward those who are reaching out in their community for everyone's benefit. The benefits of focusing on the strengths and resources as well as enhancing community connectedness in rural and regional communities is well acknowledged amongst our organisation. The pilot project will focus on groups in the Sunshine Coast and Gympie regions with hopes to extend into more northern areas of our catchment in following years.

The first round of Healthy Towns nominations open from 1 April 2016 until 30 September 2016. Winners will be announced in October 2016 and an award event will be held to celebrate the successes of our residents.

We're very focused on reaching out to groups who may be interested in apply for an award, and as such have hosted a morning tea at Maroochydore to provide groups with information on eligibility and nominations. A morning tea will also be held in Gympie Township in the coming months.

The PHN has already received plenty of interest in the awards, including engagement with history groups, community gardens, local Men's Sheds and walking groups. If you participate in a community group running an activity which contributes to local health and happiness and focuses on populations where there is a great health need then you may be eligible for a Healthy Towns Award.

For more information on Healthy Towns and how to apply, please head to the healthytowns.org.au website or contact Marianne Bell from the CSE team on **07 5456 8135.**

Pattie Hudson
CEO

DIARY DATE!

SCLMA 'CHRISTMAS IN AUGUST'

SATURDAY 13 AUGUST

SURFAIR MARCOOLA

INVITATIONS ON THE WAY!

Comparison of 1.5T vs. 3.0T Multiparametric MR Imaging in the Detection of High Grade Prostate Cancer

Scientific Formal (Paper) PresentationsPresented on December 4, 2013
Presented as part of SSK08: Genitourinary (Prostate Cancer: Multimodality Diagnosis and Staging of Disease)

Participants

Daniel Aaron Moses MBBS, FRANZCR, Presenter: Ronald C. Shnier MBBS, Abstract Co-Author: James Thompson MBBS, Abstract Co-Author: Nothing to DiscloseLee E. Ponsky MD, Abstract Co-Author: Phillip Brenner MBBS, Abstract Co-Author: Warick Del Prado, Abstract Co-Author: Andrew Hayen PhD, Abstract Co-Author: Phillip Stricker MBBS, Abstract Co-Author:

PURPOSE

Compare the efficacy of 1.5T and 3.0T mp-MRI in the detection/exclusion of high grade prostate cancer.

METHOD AND MATERIALS

A prospective study (for 300 men) was approved by the ethics board. 122 men had been randomised for mp-MRI at either 1.5T or 3T before a planned transperineal biopsy. The MR protocol included high resolution T2-weighted, diffusion and perfusion sequences without the use of an endorectal coil. Two uroradiologists used the PI-RADS reporting system independently for each scan. A combined score was attained by taking the average.

RESULTS

A total of 91/122 men received a average PI-RADS score of 2.5 or greater (intermediate to high risk of significant PCa), with 47/54 of men on the 1.5T MRI, and 44/68 of men on the 3T MRI being classified in the same way. On biopsy 48/122 [28/54 on 1.5T and 20/68 on 3T] had Gleason 7 or greater prostate cancer. 11/122 [6/54 on 1.5T and 5/68 on 3T] had greater than Gleason 8 prostate cancer.

The following results were achieved using a threshold of Gleason 7 disease and above as positive for significant disease an average PI-RADS score of 2.5 and above for suspected clinically significant disease: 1.5T: TPR 100%, FPR 73%, NPV 100%, PPV 60% 3.0T: TPR 100%, FPR 50%, NPV 100%, PPV 45% Combined: TPR 100%, FPR 58%, NPV 100%, PPV 53% Using a threshold of Gleason 8 disease and above as positive for significant disease and average PI-RADS score of 4 and above for suspected clinically significant disease: 1.5T: TPR 100%, FPR 29%, NPV 100%, PPV 30% 3.0T: TPR 100%, FPR 16%, NPV 100%, PPV 33% Combined: TPR 100%, FPR 22%, NPV 100%, PPV 31% [True positive rate (TPR), False positive rate (FPR), Negative predictive value (NPV), Positive predictive value (PPV)]

CONCLUSION

- **MP-MRI, without an ER coil, can achieve very high NPV for significant prostate cancer (in our case 100%).**
- **There was no difference between the NPV when using a 1.5T or 3T MR system.**
- **The positive predictive value was higher for 1.5T (60%) vs. 3T (45%) when choosing a threshold of Gleason 7 for significant disease.**
- **This equalised [1.5T 30% vs 3T 33%] with a threshold of Gleason 8.**

Moses, D, Shnier, R, Thompson, J, Ponsky, L, Brenner, P, Del Prado, W, Hayen, A, Stricker, P, Comparison of 1.5T vs. 3.0T Multiparametric MR Imaging in the Detection of High Grade Prostate Cancer. Radiological Society of North America 2013 Scientific Assembly and Annual Meeting, December 1 - December 6, 2013 ,Chicago

SUNSHINE COAST RADIOLOGY ®

Iliotibial Band Syndrome

Findings

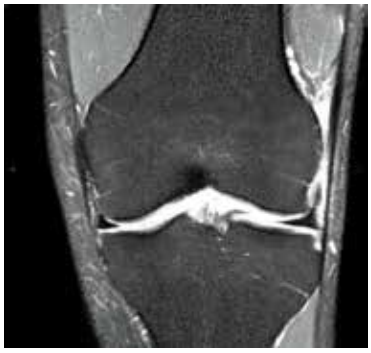
High signal edema is seen deep to the iliotibial band adjacent to the lateral epicondylar prominence of the femur. This is a common location for the IT band to be mechanically irritated.

Diagnosis

Findings in keeping with iliotibial band friction syndrome.

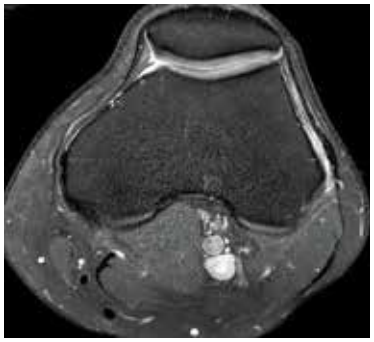
Discussion

Anatomy



The iliotibial band (ITB) is a thick band of fascia formed proximally at the hip by the fascia of the gluteus maximus, gluteus medius and tensor fascia latae muscles. It inserts onto Gerdy's tubercle on the anterior lateral tibia and the intermuscular septum of the distal femur. A small recess exists between the lateral femoral epicondyle and the ITB which contains a synovial extension of the knee joint capsule (lateral synovial recess).

Epidemiology



Typical patient is young and physically active, most often long distance runners or cyclists. The exact prevalence is unknown, but one study has found the prevalence among actively training marines to be higher than 20% . Iliotibial band syndrome accounts for 12% of running-related overuse injuries.

Clinical presentation

Classically, ITBS is diagnosed by history and physical examination. Pain at the lateral knee joint is the presenting symptom with point tenderness 1-2cm above the lateral joint line. Pain is usually worse with downhill running and increases throughout an episode of activity.

Pathology

When the knee flexes, the ITB moves posteriorly along the lateral femoral epicondyle. When the band is excessively tight or stressed, the ITB rubs against the epicondyle irritating the lateral synovial recess. Histologic analysis demonstrates inflammation and hyperplasia in the synovium. The following physical factors are reported to be associated with development of the syndrome.

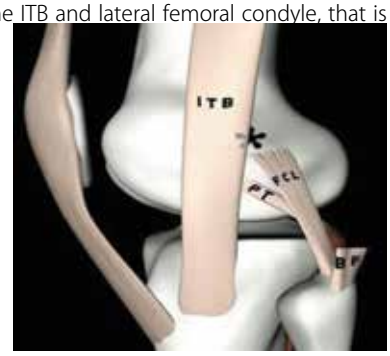
- limb length discrepancy
- genu varum
- overpronation
- hip adductor weakness
- myofascial restriction

Radiographic features

MRI

MRI is reserved for when the diagnosis is unclear and to exclude other etiologies of lateral knee pain such as a meniscal tear or lateral collateral ligament injury.

MR findings of ITBS include ill-defined signal abnormality interposed between the ITB and lateral femoral condyle, that is low signal on T1 and high on T2 weighted sequences, in keeping with oedema/fluid.



Signal abnormalities can also be seen superficial to the ITB.

Chronic MRI findings include alteration in ITB caliber.

Ultrasound

Allows visualization of the impingement by assessing dynamic motion of the ITB through knee flexion and extension.

Treatment

Initial treatment is conservative, consisting of physical therapy, anti-inflammatory medication, and steroid injections Surgical treatment is reserved only for those who fail conservative treatment, and includes resection of the posterior aspect of the ITB.

Differential diagnosis

General imaging differential considerations include

- lateral meniscal tear
- lateral collateral ligament injury

www.scradiology.com.au -August 2014

REFERENCES
http://radiopaedia.org/articles/iliotibial-band-syndrome
http://www.radsource.us/clinic/0504

Your Local Imaging Specialist

SUNSHINE COAST CARDIOLOGIST IMPLANTS FIRST REVOLUTIONARY NEW SUBCUTANEOUS DEFIBRILLATOR

Sunshine Coast University Private Hospital is the first Sunshine Coast hospital to have implanted the revolutionary new S-ICD ™ implantable defibrillator system for patients at risk of sudden cardiac arrest.

Cardiologist Dr KK Lim completed his first procedure to implant with the new subcutaneous implantable defibrillator at the Cardiac Catheter Laboratory located at Sunshine Coast University Private Hospital last week.

Dr Lim said that the device has only been available in Australia for a year and is an exciting advancement offering patients a less invasive procedure than the traditional transvenous implantable cardioverter defibrillators in which the leads are fed into the heart through a vein and attached to the heart wall.

“The device is implanted just below the skin and the lead is implanted along the breastbone, just under the skin, rather than through a vein and into the heart thereby leaving the heart and blood vessels untouched and intact,” Dr Lim said.

“It is designed to provide the same protection from sudden cardiac arrest as traditional ICDs, however as there is no direct contact with the heart or bloodstream, it avoids the risk of life-threatening infections that could travel directly to the veins and heart via the traditional ICD lead.

“The new device is a great option for young patients with congenital heart conditions as the leads can be more easily replaced as these patients grow,” Dr Lim said.

“The first procedure with the new defibrillator went extremely well and my patient was well enough to go home the next morning, following an overnight stay,” he said. “The team at the hospital that helped to achieve this good outcome included Anaesthetist Chris Graves, Scrub Nurse Lucy Fittler, Scout Nurse, Joanne Quayle, Monitor Deshna Fennell, Team Leader, Melinda Taylor and Radiographers Dani Roberts and Craig Saunders.”

The system has two main components: a pulse generator and a lead. The pulse generator is a small battery-powered device that constantly monitors a person’s heart rhythm and can provide a small electrical shock to restore the heart to normal rhythm when the heart is beating dangerously fast (tachycardia) or chaotically.

Sudden cardiac arrest is an abrupt loss of heart function. Most episodes are caused by the rapid and/or chaotic activity of the heart known as ventricular tachycardia or ventricular fibrillation.

The new treatment is suitable for a large amount of patients; however it is not intended for patients who have symptomatic bradycardia (a slow heart beat) and who require a pacemaker,” Dr Lim said.

More than 1,000 patients have been treated at the Cardiac Catheter Laboratory at the Sunshine Coast University Private Hospital this year.

Chief Executive Officer Oliver Steele said the high volume was a good indication of both the need and demand for high quality cardiac services on the Sunshine Coast together with the excellent calibre of the cardiac specialists in practice in the region and the successful outcomes for patients that are being achieved.

For further information please contact:

Cathy Barratt
Marketing and Communications Coordinator
Sunshine Coast Hospitals
BarrattC@ramsayhealth.com.au
0437 479 165

MORE OPTIONS FOR YOUR PATIENTS

WHY FERTILITY SOLUTIONS IS YOUR BEST CHOICE

His and Her Fertility Investigation Package
2 Low Cost IVF Options
Choice of Being Awake or Asleep During Procedures
Success Rates we are Proud to Share (visit fssc.com.au)
Comprehensive Range of Fertility Treatments

Now offering Low Cost IVF where embryos are transferred at an advanced stage, increasing pregnancy success rates by up to 25% (based on our clinic result for 2015 all ages)

Choice of 6 Fertility Specialists

Dr James Orford | Dr George Bogiatzis | Dr Kirsten Morrow | Dr Nerida Flannery | Dr Julienne Wickham | Dr Harrie Swanepoel

fertility solutions™
with an affordable edge

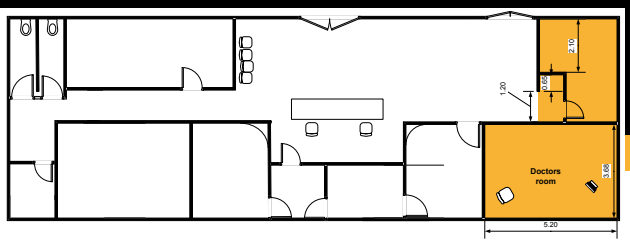
1300 FERTILITY (337 845) www.fssc.com.au

Fertility Solutions Sunshine Coast | Nucleus Medical Suites | Suite 22, 23 Elsa Wilson Drive, Buderim QLD 4556

SPECIALIST ROOMS
AVAILABLE FROM **APRIL 26TH**

CONSULTING SUITES
STILL AVAILABLE!

67 Bowman Road, Caloundra



- ✓ Large carpark & waiting room
- ✓ Radiology including MRI & Nuclear Medicine onsite
- ✓ Reception services available
- ✓ Flexible timeframes

5.2m x 3.6m & 3.0m x 4.2m spaces available

For more information please contact **Jim Aspinwall** on **0448 208 800**

FEDERAL BUDGET SUPERANNUATION SUMMARY

Poole Group
ACCOUNTANTS & INVESTMENT ADVISERS

On the 03/05/2016 the Federal Government handed down the budget for the 2016-17 year that includes some of the biggest changes to the superannuation system since 1 July 2007. **Importantly**, the budget announcements are still only **proposals** at this stage and will depend on the outcome of the upcoming election and on the proposals being legislated. Below is a summary of the main proposed superannuation changes;

Concessional Contribution Cap (CCC) Reduced to $25,000
At present the Concessional (tax deductible) Contribution cap is $30K per financial year for clients under age 50 and $35K per financial year for ages 50 and over. The proposal is from 01/07/2017 the cap will be reduced to $25K for everyone, regardless of age.

Catch-Up Concessional Contributions
Effective 01/07/2017, unused CCC amounts will be able to be carried forward on a rolling basis over 5 consecutive years from 01/07/2017. Access to unused CCC amounts will be limited to individuals with a super balance of less than $500K. The Government is using this measure to allow those who take breaks from work the opportunity to "catch up" if they have the capacity or choose to do so.

Lifetime Cap for Non- Concessional Contributions (NCC)
NCC'S relate to contributions you are putting into super in after tax dollars and where you are not claiming a tax-deduction. This is one of the biggest proposals in addition to the $1.6MIL transfer cap and effective 7:30 pm (AEST) 03/05/2016. The Government is looking to impose a $500K lifetime NCC cap which is back dated to 01/07/2007. This replaces the existing NCC caps which allow clients to put in up to $180K per financial year or $540K over a rolling 3 year period for clients aged under 65. Clients that have exceeded the cap will need to remove their contributions or be subject to current penalty tax arrangements.

Remove Contribution Eligibility Requirements for those Aged 65 to 74
At present, clients over age 65 wanting to make contributions into super need to qualify for a work test. This test is being removed and will now allow all clients under 75 to contribute to super without a work test. This proposal is effective 01/07/2017.

Introduce a $1.6MIL Superannuation Transfer Balance Cap
This proposal is effective 01/07/2017 and is designed to restrict the total amount of super that can be transferred from accumulation to pension phase to $1.6MIL. If a client accumulates more than $1.6MIL they will be required to transfer the excess back to accumulation phase where earnings are taxed at the concessional rate of 15%.

Additional 15% Contributions tax: Threshold reduces to $250K
Currently, this additional tax applies to clients who are earning above $300K p.a. and is in reference to the CCC being taxed at 30%, rather than 15%. From 01/07/2017 the proposal is for the tax to apply to clients who have income above $250K p.a.

Transition to Retirement (TTR) Pensions: Removal of Earnings Tax Exemption
At present, clients who are in a TTR benefit from a 0% tax environment on their earnings. This proposal from 01/07/2017 is that these earnings will now be taxed at 15% which is the same rate while clients are in accumulation phase.

Extend Deductions for Personal Contributions
From 01/07/2017 the proposal is will allow any client under age 75 to make personal CCC to superannuation. At present, only clients who are self-employed are able to make personal deductible contributions.

There are also some spouse superannuation tax offset and low income super tax offset changes proposed for 01/07/2017 along with anti-detriment changes and defined benefit scheme changes. Importantly, as mentioned these are not legislation yet but it is important to speak to a qualified adviser about potential impacts on your person situation and options that could benefit you prior to 01/07/2017.

If you would like to talk about the effects the changes may have on your own personal situation feel free to give me a call. Hayden White, Poole & Partners Investment Services Representative. **07 5437 9900** **hwhite@poolegroup.com.au**

MONTSERRAT
— CANCER CARE —

First in to Queensland to reduce Chemotherapy induced hair loss with the Cold Caps/Scalp cooling treatment

One of the most frequent questions we hear from patients when they discover they need Chemotherapy is, Am I going to lose my Hair?

We are proud to announce that The **Sunshine Coast Haematology & Oncology Clinic** are the first in Queensland to officially offer patients a scalp cooling treatment (Paxman) that can prevent Hair loss caused by certain Chemotherapy drugs. *The service will be available at our Sunshine Coast Clinic.*

The treatment is clinically proven to be an effective way of combating Chemotherapy-induced hair loss and results in a high level of hair retention. It can be used with all solid tumor Cancers that are treated with chemotherapy drugs such as Taxanes (eg docetaxel), Alklating agents (eg cyclophosphamide) and anthracyclines/DNA intercalating agents (eg doxorubicin). The treatment cannot be used with Haematological malignancies, cold allergy suffers, cold agglutinin disease, presentation of scalp metastases and disease requiring imminent bone marrow ablation chemotherapy.

How does it work? The Paxman system causes blood vessel vasoconstriction, which reduces blood flow in the scalp to 20-40 % of the normal rate, resulting in less chemotherapeutic drug being delivered to the hair follicles. The drug infusion rate across the plasma membrane is reduced therefore decreasing the drug dose level entering the cells around the scalp. The system has been treating tens of thousands of patients annually throughout the world with a success rate from 56% to 73%. Efficacy studies in the United Kingdom show 89% efficacy. A comprehensive Clinical evidence report can be found at: http://paxmanscalpcooling.com/the-system/clinical-efficacy

We will be offering this as an additional treatment to our patients who met the criteria at **no cost.**

Further information can be found at www.schoc.com or www.facebook.com (Sunshine Coast Haematology and Oncology Clinic Friends)
at the Paxman website: www.paxmanscalpcooling.com ; or
by calling Clinical Nurse Manager Kim McCullough on: (07) 5479 0000.

SUNSHINE COAST
HAEMATOLOGY & ONCOLOGY CLINIC
– Montserrat Cancer Care –

**The Orbis Cooling machine*

www.schoc.com.au

SUNSHINE COAST RADIOLOGY®

Nuclear Medicine + Radiology, Best of Both Worlds

Specialists at Nuclear Medicine

- Dual qualified Nuclear Medicine Radiologists who
  - Can correlate all diagnostic images to achieve the best possible result for patients.
  - Can combine CT and Nuclear Medicine to improve the accuracy of diagnosis.
- Comprehensive services are offered to our patients.
- All Medicare eligible Nuclear Medicine services are Bulk billed.

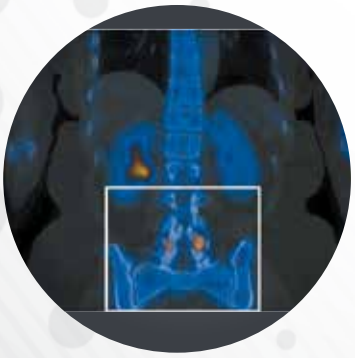
Dr. John Evans

MBBS, B Med Sci (Hons), FRANZCR
Nuclear Medicine Specialist

Dr John Evans obtained his medical degree from the University of Tasmania in 1988. Dr Evans completed his Radiology training in 1996. During this time he worked at Royal Canberra Hospital, Woden Valley Hospital Canberra, Royal Brisbane Hospital, Royal Infirmary and Western General Hospital Edinburgh. Dr John Evan's Nuclear Medicine training was at Princess Alexandra Hospital and Addenbrookes Hospital Cambridge finishing in 2001. He is accredited for PET and CT Coronary Angiography and performs many interventional procedures. He has spent 12 years at Cairns Diagnostic Imaging including 11 years as manager and MRI supervising radiologist. He has also been the supervising radiologist at Breastscreen QLD.

Bulk Billing

"medicare eligible services"



Dr. Mark Sinnamon

MBBS, FRANCZR, FAANMS

Dr Mark Sinnamon graduated from the University of Queensland in 1990. He completed his training at the Princess Alexandra Hospital Brisbane and completed further training at the Wesley PET Centre & Nuclear Medicine Brisbane. Mark is a member of Australian and New Zealand Association of Nuclear Medicine Physicians with accreditation in Nuclear Medicine and PET imaging.

Sub-specialists interests
- Oncology
- Musculoskeletal (MSK) Imaging

Sunshine Coast University Private Hospital
3 Doherty St, Birtinya ,QLD 4575

Maroochydore
60 Wises Road, QLD 4558

1300 MY SCAN
Booking 1300 69 7226

GP EDUCATION

Doing it for Doctors
PARTNERS IN GP EDUCATION

Going for Gold!

breasts, rehabilitation, Barrett's O, shoulders, obesity, stroke and falls

Join Noosa Hospital for some 'speed up-dating', and short sharp 10 - 15 minute takeaways from our team of specialists at Noosa Hospital.

PROGRAM

6.15pm Registration & dinner

7.00pm Welcome & introductions

Round table discussions:

Breast lumps and nipple discharge,
Dr Felicity Adams, *Breast, Endocrine and General Surgeon*

Rehabilitation medicine – the holistic approach,
Dr Zeshan Ali, *Rehabilitation Medicine Physician*

Barrett's oesophagus screening and surveillance – highlights from the new Australian guidelines,
Dr Simone Kaye, *Gastroenterologist*

My shoulder is sore doc, Dr Gerard Kilian, *Orthopaedic Surgeon*

Surgical management of morbid obesity and metabolic disease, Dr Garth McLeod, *General and Bariatric Surgeon*

Rehabilitation medicine management of stroke and falls,
Dr Catherine Macintosh, *Rehabilitation Medicine Physician*

9 00 pm Evaluation & close

Approved 4 QI&CPD Category 2 points

When:
Tuesday, 14 June 2016

Where:
Kingston House "Impressions"
Cnr Channon and Barter Sts,
Gympie 4570

RSVP:
Wednesday, 8 June, 2016

It's easy to register

Register online at www.noosahospital.com.au
Email Pam Bull at bullp@ramsayhealth.com.au
Information call Pam Bull, GP Liaison 0427 327 321

Name: ..... **QI&CPD:** .....

Practice: ..... **Mobile:** .....

Email: .....

Dietary Requirements: ☐ **Vegetarian** ☐ **Gluten Free** ☐ **Other** .....

NOOSA HOSPITAL

Email us if you wish to be removed from our mailing list

CRT Network SOLUTIONS

Medical IT Support
Medical & Pharmacy IT Specialists

"We greatly value the work ethic of CRT Network Solutions – they make excellent recommendations when they need to make upgrades to our network but are also honest enough to say when we don't. We have forged an amicable working relationship together and can unreservedly recommend their expertise. I have no hesitation in recommending Chris and the CRT team."

Adam Ryder – Coastal Family Heath

"When problems arise, CRT respond to my calls promptly and efficiently. I recommend CRT Network Solutions unreservedly for any of your IT needs."

Jean Currin – Beerwah Medical Centre

"CRT pride themselves on promptness of response and I feel that this is what they deliver, not to mention experienced staff who will ensure a job well done before leaving site. I have no hesitation in recommending their services and expertise to other medical practices. They do an excellent job and our computers run consistently smoothly."

Elsie – Maroochy Medical Centre

Visit our webpage

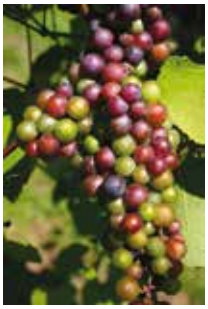
www.crtnetworksolutions.com.au

TRY OUR SERVICES, IT'S FREE!

1 ½ HOURS FREE TRIAL OF OUR SERVICES AVAILABLE TO ALL BUSINESSES.

*Obligation Free - Parts not included.

1300 760 339 YOUR MEDICAL IT EXPERTS



Nebbiolo – lifting the fog

dr. plonk

Why Nebbiolo? I asked this question of Karen Coats and Dr Prue Keith, owners of Virago Estate in Beechworth, Victoria. They both replied that the serendipitous exposure to this red grape variety left an alluring wine experience something akin to the sirens of Homer's Odyssey.

Why Nebbiolo?; it's such a finicky, lesser known red grape that is tricky to grow with early bud burst and late ripening often requiring soils dominated by calcerous marls. It requires meticulous hands on efforts. Perhaps the team of Karen ,being and ex tax accountant, Dr Prue a practicing Orthopedic Surgeon and the wine maker Ric Kinzbrunner (owner of Giaconda), a retired Engineer, may have led to a team with enough OCD to tackle these vagaries.

Nebiollo is an ancient grape first mentioned in the 13th century. The Italian word for fog is "nebbia". This probably refers to the" fog like" cover over the skins of the dark gray Nebbiolo grape. It has been suggested that the reference to fog describes the Valley in Piedmont as the fog rolls in in late autumn.

The Piedmont region, North Western Italy, at the foot of the Alps is home to sumptuous foods including truffles. Barolo and Barbaresco are the most lauded of Nebbiolo "Cru" regions. It is Burgundian-like in the classification restrictions along with the atmosphere involving the marriage of traditional food and wine. This also brings up the comparison to Pinot Noir, another finicky grape that rewards its grower with tantalizing bouquets and multi layered structural elements.

Why Nebbiolo? It seems fitting that an ancient grape variety is finding its place in the ancient soils of Beechworth. This pocket of paradise must surely be tied in a kindred spirit to Burgundy and Piedmont.

Beechworth exudes its own array of amazing local produce and Wine producers. Some of the country's best vignerons include Savaterre, Castanga, and Giaconda etc. Akin to Piedmont, the fog forms in the Valleys of Beechworth after picking season.

Karen and Dr Prue are the type of wine growers that keep passionate authors writing about wine. There is the enthusiasm and proudness of newly expectant parents.

There is the sense of focus and determination; there is the sense of artistry with producing Nebbiolo. In 2007, 2100 vines were hand planted. Organic principals are called upon but not as a definitive process. It's what Karen and Prue believe is best for the vines and hence the wine.

I firmly believe that Nebbiolo is the next journey of discovery in wine in Australia. Merlot had a run but pulled up lame. Shiraz and Cabernet Sauvignon are still powerful in their own right. Wines like Nebbiolo, Pinot Noir and Riesling are renowned for expressing their terroir. To me, this means that these wines are guided by the winemaker and when drunk, transport you to that birthplace of the vine.

Wines Tasted

2011 Virago Nebbiolo Beechworth- Light garnet with tinges of brown in couloir. The initial bouquet includes rose petals, sundried fruits and Herbs. A complex vanillin aroma hides in the background. After 1 hour, the bouquet developed into dusty glazed cherries, rose petals and some earthy funk characteristics. An amazing transformation. The palate dances and flitters on the taste buds. It surfs easily over the palate with well supporting tannins and acidity. Will cellar for a decade. Have with Thyme roasted Pousson.

2012 Virago Nebbiolo Beechworth- Brighter garnet in color, exuding youth. Brighter red fruits with essence of smoky notes. As the wine opened up, candied fruits, more delicate then a Grenache, with herbal notes were released. This is quite a youthful camouflaged beast of a wine. The wine stands up boldly in the anterior palate then pauses slightly, enough to give space for the structured tannins to shine. Cellar 15y plus Have with wild Duck Pie.

Dr Plonk

BOSNIA AND HERCEGOVINA- A LAND OF RAW CHARM & SPLENDOUR

Bosnia and Hercegovina is a melting pot of history, culture and natural beauty. The country's abundant highlights are a beautiful amalgamation of Ottoman and Austro-Hungarian histories. Be it rafting, skiing, wine touring, visiting the historical and architectural centres, or enjoying their rich and unique coffee culture in a dainty café, a trip to the intriguing Bosnia and Hercegovina will surely be one fascinating entry in your diary.

Bosnia and Hercegovina's Wonders

- **Tunnel Museum:** Located in Sarajevo- Bosnia's capital, the tunnel museum is perhaps the closest we can get to witness the consequences of the civil war in the 1990s.
- **Stari Mosti (Old Bridge), Mostar:** A UNESCO World heritage site, the bridge's arch stands magnificent against the golden sky at dusk or the aesthetic night-time floodlighting. Sit by the cafes strategically set up nearby and savour the splendid view.

For the Adventure-Hungry

- **Sutjeska National Park:** explore the lush Perućica- Europe's primeval native forest and, Sutjeska National Park, which also offers mountain biking and hiking access to some picturesque upland lakes.
- **Skiing at Bjelašnica:** located near the Sarajevo compact airport, you could hop off the plane and slide through the snow blanketed slopes in an hour! Floodlit night-skiing is a popular attraction. The villages behind the Bjelašnica offer a gamut of exploration opportunities on a mountain bike or foot.
- **Una Valley**: the rapids and waterfall of this valley are thrilling. The imposing **Štrbački Buk** waterfall is the showstopper of the Una National Park and definitely worth a visit. It also has one of the most adventurous rafting stretches.
- **Daredevil Bridge jumping in Mostar**: Who wants to bungee jump when you could savour the exhilarating tradition of jumping off the Old Bridge 20m down into the icy waters of River Neretva?

For the history addicts

- **Tejika**: the charming half-timbered Dervish house supposedly from the 16th century is the main attraction of the city of Blagaj. Tejika stands beside the surreal blue-green Buna River where it surges out of a cliff-cave. Breathtaking!
- **Počitelj:** the breathtaking fortress village from the Ottoman era is a fine example of architectural wonder. The part-ruined complex with stone-roofed houses, clock tower, mosque and the iconic Gavrakapetan tower fills you with an inexplicable nostalgic aura.

What have we planned for you?

A comprehensive itinerary has been complied to include all the exciting attractions of the beautiful Bosnia and Hercegovina.

- *Guided tour to the Sutjeska National Park with hiking and mountain biking opportunities*
- *Wine touring in Hercegovina*
- *A day at Bjelašnica with skiing, and other excursions included*
- *A guided day trip to Mostar from Dubrovnik with stop at the fortress town of Počitelj, the historic Old Bridge, Old bazaar among others*
- *Trip to the Una River, the glorious Ostrožac Fortress, and the Štrbački Buk waterfall along with rafting opportunities*
- *An evening filled with drinks, local sweets, delectable cuisine and, Sevdah –traditional Bosnian music playing in the backdrop at Kuća Sevdaha.*

www.123Travelconferences.com.au

THE BIOLOGICAL CLOCK

By Denise Donati (Director Fertility Solutions)

As women and men delay childbearing, there is now an unrealistic expectation that medical science can undo the effects of aging – unfortunately even with IVF this is not so. In a three part information exchange I will share some research and knowledge that surrounds the "Human Biological Clock"

Part 2 - Soft, medium or hard boiled – does female age affect your eggs?

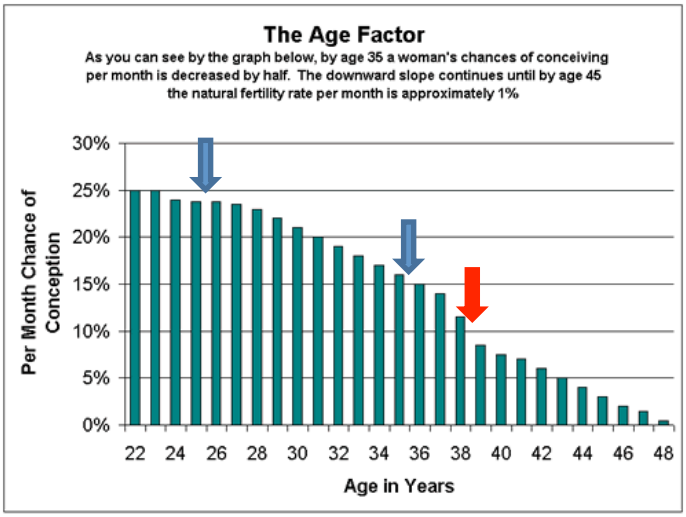
In part 1 of The Biological clock, it was discussed that whilst men continue to produce sperm throughout their lives research is now suggesting that quality is compromised. It is also now known that men under the age of 40 have an increased chance of a pregnancy & healthy baby compared to men who are over 40. Today we focus on the female age and if it has an effect on fertility.

A very important concept that health care providers working in infertility should clearly convey to our patients is that females are born with a full complement of oocytes with no more being acquired during a female's lifetime. It's fascinating to think that women are born with around **2 million** oocytes, by puberty, only **300 to 400 thousand** oocytes remain and from puberty onwards **5 – 10 thousand** oocytes undergo natural atresia each month

Irrespective of what people may think **nothing stops this loss –** NOT even the pill or pregnancy

Figure 1 shows a very familiar curve that demonstrates female fertility peaking in the mid 20's, drops at about the age of 35 and a reasonably big drop at the age of 40 until menopause when the ovaries are devoid of follicles.

Figure 1: Female Age and Chance of conception



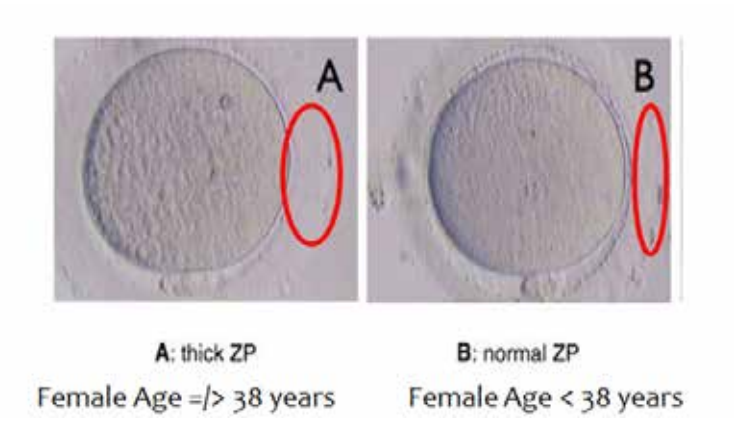
As doctors and nurses providing fertility care and education to patients it is important that due consideration be given to the following statistics when advising women on fertility:

- Female fertility reaches its peak at 27 years of age and then slowly declines thereafter
- A woman under the age of 35 has a risk of miscarriage around 15%
- From 35 to 45 the risk of miscarriage increases to somewhere between 25-35%
- When a woman reaches the age of 40, approximately 90% of her oocytes are abnormal
- At the age of 45 the risk of miscarriage is approximately 50% with a less than 5% chance of pregnancy
- When the age of the female increases to 44 the implantation rate drops to less than 5%. When a woman's age is greater than 44 implantation drops and down to around 2%.

So why is female age important?

Research conducted in 2001 by Peterson et al looking at a women's age and its effect on the thickness of the zona pellucida, confirmed a significant differences in zona thickness between embryos from older women, that is 38 years or older and embryos from younger women less than 38 years (Figure 2). This research confirmed opinions that zona thickness is affected by female age.

Figure 2: Zona Pellucida Thickness and Female Age



In 1995 Betrand and colleagues examined what if any influence zona pellucida thickness had on fertilization rates. This research validated that a thick zona had a positive correlation with failed fertilisation. The research also showed that even with normal semen, the zona pellucida of fertilised oocytes was significantly thinner than the zona of unfertilised oocytes.

It therefore stands to reason should an embryo have a thickened zona and still manage fertilisation that the thickened zona could possibly influence its ability to hatch and subsequently implant into the uterine endometrium.

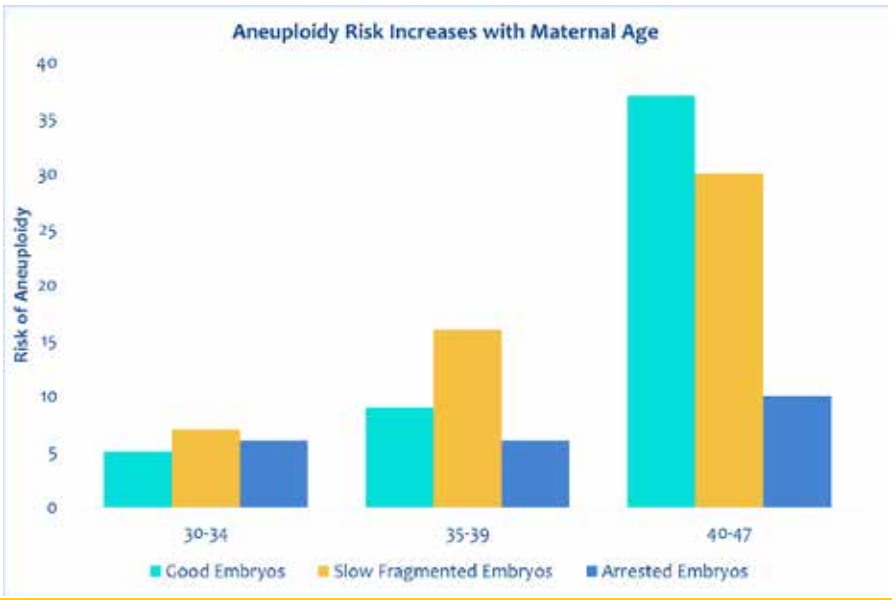
Oxidative Stress

As females age there is a rise in oxidative stress levels. This oxidate stress at the cellular level results in free radicals being produced. These free radicals circulating within the oocyte then leads to mitochondrial and meiotic dysfunction with the end point being an increase in embryo aneuploidy, fragmentation and arrest (Figure 3).

Short telomeres fact or fiction?

Courtney and colleagues in 2009 reported that short telomeres promote end-to-end joining of affected chromosomes and chromosomal instability which results in an increase in recurrent miscarriages due to embryo diploidy, anueuploidy and other anomolies such as polyploidy & translocations (Figure 3). Courtney also reported in the study that there was possibly a positive correlation between short telomeres and Premature Ovarian Failure (POF).

Figure 3:



What is interesting to note is that oocytes donated from younger women completely abrogate the effects of reproductive aging. This further highlights the central role of oocytes in reproductive aging rather than endometrial receptivity.

The State of the Uterus

The final factor that needs to be taken into account when considering the impact of female age on fertility is the uterine environment and in particular endometrial polyps and fibroids

Uterine polyps grow from the endometrium with the incidence increasing with age, traditionally the incidence peaks between 40 and 50 years of age and gradually declining after menopause. It is estimated that 20% to 50% of women between ages 30 and 50 have fibroids. By the age of 40, approximately 40% to 70% of women may have them.

Studies have shown that uterine polyps have a significant effect on fertility with fertility significantly improving for women who have their polyps removed compared to those who do not however, the exact reason that polyps affect fertility is unknown, but it is postulated that it may be related to inflammation in the uterine lining.

The second mostly commonly observed uterine anomaly that increases with female age is Fibroids which are most common in women in their 40s and early 50s with approximately 70 to 80 percent of women developing fibroids by the time they reach the age of 50.

However the mere presence of a fibroid alone does not necessarily cause infertility the impact if any, is related to the type and location. Submucosal fibroids are the type that have clearly been demonstrated to reduce pregnancy rates, roughly by 50%, and removal of which can double pregnancy rates. In some cases, simply removing the submucosal fibroid solves infertility.

So the research is clear when it comes to female age and fertility with there being a positive correlation with advanced female age and zona implications, a decrease in oocyte quality and telomere length all leading to oocyte incompetence and subsequent mitochondrial implications.

Next month – Part 3 Is there such a thing as the Fountain of Youth?

References:

Bertrand, E., Van Den Bergh, M., and Englet, Y., Fertilization and early embryology: Does zona pellucida thickness influence the fertilization rate? 1995, Human Reproduction, Volume 10, Issue 5, Pp. 1189-1193.

Courtney W. Hanna , Karla L. Bretherick, Jane L. Gair, Margo R. Fluker, Mary D. Stephenson, and Wendy P. Robinson, Telomere length and reproductive aging, 2009, Human Reproduction, Vol.24, No.5 pp. 1206–1211

Petersen C., Mauri, A., Ferreira, R., Baruffi, R., Franco, J., Women's age affects the thickness of the zona pellucida, Fertility and Sterility, September 2001, Volume 76, Issue 3, Supplement 1, Page S272

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: For members who wish to receive hard copies (instead of by email) of the monthly invitation & newsletter by Sullivan Nicolaides Pathology Couriers to avoid postage costs.		
	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	**$ 77**		**Your Monthly Invitation?**	
Doctor spouse of full-time ordinary member	**$ 33**		By Email?	
Absentee or non-resident doctors	**$ 33**		By Courier?	
Part-time ordinary members (less than 10 hours per week)	**$ 33**		By Post?	
Non-practising ordinary members, under 60 years old	**$ 33**		**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
OR: FAX TO 5479 3995 PLEASE NOTE HALF PRICE MSHIP CONTINUING THIS YEAR!

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 INC
MANAGEMENT COMMITTEE MEETING
THURSDAY 24 MARCH 2016
Maroochydore Surf Club Function Room, Maroochydore
MINUTES
(Accepted at Committee Meeting 28 April 2016

Attendance: Drs Di Minuskin, Wayne Herdy, Marcel Knesl, Kirsten Hoyle, Jeremy Long, Nigel Sommerfeld, Jon Harper and Scott Masters.

Apologies: Drs Jenny Grew, Peter Ruscoe, Mark de Wet and Mason Stevenson.

Minutes of last meeting: *25 February 2016 (To be accepted).*
Moved: Di Minuskin Seconded: Kirsten Hoyle. Carried.

Business arising from Minutes: *Nil.*

President's Report: *Dr Di Minuskin*

- Since last month when I spoke about the proposed urgent care centre at Caloundra Hospital, I have attended further meetings with Mark McArdle and then Kevin Hegarty several days later. Both reinforced the decision that some service would remain at Caloundra. However Kev Hegarty said the suggestion that it would be staffed by one GP as suggested in the meeting attended by a group of Caloundra GPs and executive staff from the SCHHS was not decided. He promised further consultation with the medical community in Caloundra.
- I have attended two meetings now to discuss submission of an application to the ICIF. (Integrated Care Innovation Fund).
- Tour of the SCUH since the last meeting. Very impressive on several fronts. Firstly the massive size of the construction but also the increased services that accompany the opening. What was also impressive was the Heads of Dept enthusiasm and ownership. Seems to be a real opportunity for changes to improve the health outcomes of our patients. But also a real opportunity to improve the integration of services between primary care and the hospital.

Vice President's Report: *Wayne Herdy. Apology*

Secretary's Report: *Dr Jenny Grew - Apology*

Correspondence In:

- Dr Sandra Peters – GP Connections (SCHHS Newsletter)
- USC – Confirmation of SCLMA details to be included on Donor Recognition Wall

Correspondence Out: *Nil*

Business arising from Correspondence:

- Di talked about GP Connections.

Treasurer's Report: *Dr Peter Ruscoe*

a) Accounts to be paid:

- Australia Post – February 2016 Account
- Office National – February 2016 Account
- Jo Bourke – Secretariat February 2016
- Jo Bourke – Adobe CC subscription February 2016
- Snap Printing – Invites March 2016
- Snap Printing – Newsletter March 2016
- Jo Bourke – Newsletter March 2016
- Chris Lonergan – Refund of classified payment

Moved: Peter Ruscoe that the accounts as tabled be approved for payment.
Seconded: Di Minuskin. Carried.

(b) Membership Report:

- Dr Garth McLeod (General Surgery, Bariatic Surgery)
- Dr Ali Sharafi (Endocrinologist, Diabetes Specialist)
- Dr Peter Stickler (General Practice)
- Dr Peter de Wet (General Practice)
- Dr Dion Noovao (Orthopaedics)
- Dr Stefan Buchholz (Cardiology)
- Dr Paul Hlincik (General Practice)

Moved: Peter Ruscoe that the applications for membership be accepted.
Seconded: Jeremy Long. Carried.

AMAQ Councillor's Report: *Dr Wayne Herdy – Apology.*

Meetings Convenor Report: *Dr Scott Masters*

- Monthly meetings mostly organised for 2016.
- Need to decide on venue and date for yearly social function. Suggestion to date is Ramada (Surfair). Scott suggested Mantra at Mooloolaba. Jo to contact.

Hospital Liaison Report: *Dr Jeremy Long*

- Decision to delay opening of SCUH to April 2017 was wise and had unanimous agreement.
- Focus on integration of services and integration with external services continuing.

PHN Country to Coast Report: *Dr Jon Harper*

- The SPOTON hospital avoidance trial has begun and a steady flow of data is being collected regarding QAS presentations and outcomes. So far no significant adverse events. Dr Sandra Peters, Di Cross and myself presented the SPOTON initiative at the National GPLO Conference in Canberra on 18th March.

SUNSHINE COAST LOCAL MEDICAL ASSOCIATION INC
MANAGEMENT COMMITTEE MEETING
THURSDAY 24 MARCH 2015
Maroochydore Surf Club Function Room, Maroochydore
MINUTES /cont:
(Accepted at Committee Meeting 28 April 2016

- The PHN has been working with the SCHHS to develop applications for Queensland Health's Integrated Care Innovation Fund (ICIF). Several applications were eventually submitted, ranging from specific clinical services to the development of a regional 'Integrated Care Alliance'. It should be noted that the process of creating these applications has, in itself, has produced a positive collaborative mood among many senior clinicians and health executives which can only benefit any future integrated care activities.

General Business:

- President Di reported that she will be absent for the April 28 meeting.
- Vice President Wayne Herdy to chair the meeting.

Meeting Close: 1850.

Next meeting:

Mdore Surf Club – Thursday 28 April 2016

Speaker: Dr Ethan Oost, Anatomical Pathologist, Qml Pathology

Speaker: Dr Alana Harris, Cardiologist

Jo Bourke

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"

PLEASE NOTE THE FOLLOWING:

The anti discrimination commission of Queensland has the following statement on job advertising:

Discriminatory advertising is against the law. Job advertisements need to give the impression that all suitable applicants are welcome to apply. References to sex, relationship status, age, race, religion etc should be avoided, as should the use of words that may indicate a preference for particular groups or may discourage others from applying, eg foreman, tradesman, glamorous, well-built, mature, youthful, office girl etc. Publishers can be fined and be the subject of a complaint to the Commission for publishing discriminatory advertisements that show an intention to contravene the Anti-Discrimination Act 1991. Discriminatory advertisements will therefore often be refused or modified by publishers in order to avoid legal liability.

Take Five .....

Eating in the 1950s and 1960s - in Australia

Pasta was not eaten in Australia
Curry was a surname.
A takeaway was a mathematical problem.
A pizza was something to do with a leaning tower.
Tofu and Soy, never heard of them.
Rice was only eaten as a milk pudding.
Calamari was called squid and we used it as fish bait.
A Big Mac was what we wore when it was raining.
Brown bread was something only poor people ate.
Oil was for lubricating, fat was for cooking.
Tea was made in a teapot using tea leaves and never green.
Sugar enjoyed a good press in those days, and was regarded as being white gold.
Cubed sugar was regarded as posh.
Fish didn't have fingers in those days.
Eating raw fish was called poverty, not sushi.
None of us had ever heard of yoghurt. -
Cooking outside was called camping.
Seaweed was not a recognised food.
"Kebab" was not even a word, never mind a food.

How Do Court Reporters Keep Straight Faces?
These are from a book called Disorder in the Courts and are things people actually said in court, word for word, taken down and published by court reporters who had the torment of staying calm during the exchanges.

ATTORNEY: What is your date of birth?
WITNESS: July 18th.
ATTORNEY: What year?
WITNESS: Every year.

ATTORNEY: This myasthenia gravis, does it affect your memory at all?
WITNESS: Yes.
ATTORNEY: And in what ways does it affect your memory?
WITNESS: I forget..
ATTORNEY: You forget? Can you give us an example of something you forgot?

ATTORNEY: The youngest son, the 20-year-old, how old is he?
WITNESS: He's 20, much like your IQ.

ATTORNEY: How was your first marriage terminated?
WITNESS: By death..
ATTORNEY: And by whose death was it terminated?
WITNESS: Take a guess.

CLASSIFIEDS

RUSSELL BOURNE - RETURN TO WORK
Russell wishes to thank everyone for their support and understanding through his recent illness.
Returning to work part-time from 14 June 2016 and will increase workload slowly. **Contact: 07 5444 0355**
May 2016

VR GP LOCUM REQUIRED - SEPTEMBER
- Cotton Tree 12th September 2016 for 4 weeks.
- Hours flexible. Remuneration negotiable

Please contact Jenny for more details.
Email: jenny.i@westnet.com.au
May 2016

BEST POSITION
Unit available in dedicated Medical Building directly in front of the new Sunshine Coast Public Hospital. This is the best position within the new Health Hub at the Sunshine Coast, and is the first building completed in the area:
- Lot 603 is 85sqm and located on the top floor of the "Pulse" Medical Building
- Panoramic views to the south, looking back at the Hospital and plenty of natural light
- Located in a purpose built medical building in the Kawana Health precinct
- Dedicated car parks, lift access and retail amenity at ground level
- Other tenants include QML, QDI (Radiology), Coffee Club, Raw Energy Cafe & others
- Tenancy available for lease now

Contact Owner on **0421 315 448 o**r CBRE Real Estate
1st Floor, 11 Walan Street | Mooloolaba, QLD 4557
T 61 7 5457 5757 | F 61 7 5457 5700 | M 61 0402 159 588
April 2016

DAVID COLLEDGE – MEDICAL LEAVE.
Dr David Colledge is currently on unplanned medical leave and will be away from work until Monday July 4th 2016.
During Dr Colledge's absence Dr Drago Popovic, General and Colo-rectal Surgeon, has kindly agreed to act as locum to provide continuity of care of current patients and new referrals. Please address any enquiries or referrals to either Dr Colledge or Dr Popovic c/o
Sunshine Coast Specialist Centre
Suite 9B, Nucleus Medical Centre
23 Elsa Wilson Drive. Buderim. 4556.
Ph: 5478 1449 Fax: 54442740 Email: admin@dcolledge.com.au Also available via Medical Objects
April 2016

MOVING - Dr CRAIG WRIGHT, RESPIRATORY PHYSICIAN
New Premises - Pulse Oceanside Medical,
Suite 608/11 Eccles Boulevard, Birtinya 4575.
Located opposite SCUH/SCUPH these offices have 4 dedicated patient car parks on site as well as a public car park 1 block south. There will be a second consulting room available for full time or sessional rental.
Enquiries: Dr_Craig_Wright@hotmail.com.au"
April 2016

CONSULTING SUITES AVAILABLE SCUPH
Consulting suite at Sunshine Coast University Private Hospital has rooms available for lease on short term or longer term basis.
Flexible terms available
High standard of fit out.
Reception support available on negotiation.
For further details please contact Christine 07 5437 7633.
April 2016

FOR SALE - CONSULTING ROOMS, WITH HOME ABOVE AND OFFICE BELOW
- Recently used by a psychiatrist.
- Some office furniture.
- Council approved and off-street parking.

Any interest - please ring Tanya Montgomery at McGraths 0414 260 711
March 2016

FEMALE VRGP MOOLOOLABA
Busy not for profit clinic is seeking a female VR GP to work with a supportive and relaxed team of GPs and nurses offering family planning services in Mooloolaba.
- Hourly rate, work at your own pace with no particular number of clients to be seen per hour.
- Fully computerised using Best Practice software.
- Work as many or as few hours as you like.
- Would suit a semi-retired GP or a GP with young children who would appreciate flexibility.
- No after hours or weekend work (unless you want to).
- The opportunity also exists to be involved in decision making and goal setting for the clinic.

Please contact Wendy Stephenson on 5444 8077 or 0416 938 040, or email womenshealthcare@bigpond.com
March 2016

FEMALE VR GP REQUIRED - GOLDEN BEACH
Female VR GP required for doctor owned Family Medical Centre in Golden Beach, Caloundra.
- Long established, accredited and fully computerised, General Practice with full time experienced Nurse and Receptionist support.
- Visiting Allied Health Professionals on site.
- Pathology on site and X-ray facilities next door to the practice. Mixed billing and flexible working hours are available.
- Saturday mornings are on a rotating roster.

Please see our website: www.goldenbeachmedicalcentre.com.au
For further information please contact Practice Manager: Karen Clarke on 07 54921044 or e-mail gbmedcentre@bigpond.com.au. (Afterhours on 0438 416 917)
March 2016

SPECIAL OPPORTUNITY -MAROOCHYDORE
Special opportunity for a VR GP who is seeking to take up an existing patient load of a departing colleague at our busy, well established non-corporate Family Practice.
We are a fully accredited, fully computerised, mixed billing practice with a friendly and happy professional team including nursing support and a fully equipped treatment room. Please contact the Practice Manager:
pm.wrmc@yahoo.com.au or 0409 447 096
Continuing as per request.

FEMALE VR GP REQUIRED – PELICAN WATERS FAMILY DOCTORS
Female VR GP required for doctor owned Family Medical Centre in Pelican Waters, Caloundra.
Long established, accredited and fully computerised, General Practice with full time experienced Nurse and Receptionist support. Visiting Allied Health Professionals and pathology on site. Mixed billing and flexible working hours available. For further information please contact Practice Manager: **Karen Clarke on 07 5492 1044 or e-mail gbmedcentre@bigpond.com.au. (Afterhours on 0438 416 917)**
Continuing as per request.

Classifieds FREE for members, $110 for others.
Ph Jo 0407 037 112

SCLMA CLINICAL MEETING - 28 APRIL 2016

Maroochydore Surf Club Function Room, Maroochydore

Speakers: Dr Ethan Oost, Anatomical Pathologist, QML Pathology & Dr Alana Harris, Cardiologist

Topics: *'Update on Lung Cancer & Cryoblation of Atrial Fibrillation'*

Presenter, Dr Ethan Oost with Samantha Rowe from QML Pathology (Co-Sponsor)

Mr Aaron Bartolo from QML Pathology (Co-Sponsor)

Adriana Leonardi from The Sunshine Coast Private Hospital (Co-Sponsor)

Dr Wayne Herdy is registered to participate in the 2016 Variety Bash. Cars have to be over 30 years old! He has bought a 1986 Mercedes Benz 280SE (cost $800!) and his co-driver Keith Beard has been working to get it roadworthied and registered.
The 2016 Bash will start in Warwick on Friday 30th September and finish in Bathurst on Saturday 8th October, the day of the big race.

SCLMA CHRISTMAS in AUGUST 2016

DATE: SATURDAY, 13 AUGUST

VENUE: SURFAIR, MARCOOLA

Cost: $55 each for members & partners

Pre-dinner drinks, 3 course meal, beverage package.
Guaranteed entertainment from Santa & the M7 Band!