RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
FEBRUARY 2016

Immigration and Immigrant Ships Moreton Bay Part III Colonists From Germany Continued

See Where We Work & Live continued on page 20.

President's Report Dr Robert (Bob) Brown

The Northside Local Medical association had its February dinner meeting and combined AGM on Tuesday night at the Victoria Park Golf Club on Tuesday night. The meeting was sponsored by Indivior with our speaker, Dr James (Jim) Finn, speaking on Opioid Dependence – The Brain as a Chronic Disease.

It was a well-attended and lively meeting with good debate on the topic of addiction as well as considered argument on the future of our LMA. The executive was elected unchanged and I wish to thank our hard-working committee of Graham McNally, Ken Fry and Ian Hadwen.

Unfortunately our long standing arrangement with QML is no more and we are exploring other support structures, especially looking to a healthy working arrangement with AMAQ.

We thank the AMAQ President, Dr Chris Zappala, for his attendance and presentation to our members and guests. The issues raised were many and varied. Chris has told us that the sale of Hunstantoun did not proceed at auction. The "lock out" legislation is to be introduced next week and Chris was encouraging doctors to attend the open debate at Parliament House this coming week.

Before moving on to LMA matters, I wish to acknowledge the passing of esteemed colleagues in the recent weeks. These include, Emeritus Professor Tess Cramond, Dr Andrew Jenkins and Dr Reg Neilsen. May they rest in peace.

Our discussion on our NLMA as well as the need to promote and enrich other local medical associations was wide-ranging and we encourage our associations to join with the AMAQ to advance this very necessary section of our profession. We need to look towards membership and try to foster the previous policies of encouraging all members of the profession to join. We need to be able to represent both public and private, GP and Specialist, as well as doctors employed in hospitals, public health and universities. We should look to ways of incorporating our registrars, medical officers and students.

We hope to represent our profession to the public and to the health community, including government at all levels, and to bodies such as the Metro North PHN, public and private hospitals, Queensland Health, and community groups. I would like us to be a natural body for the press to contact regarding local health issues. We need to foster leadership in our younger doctors so that a strong medical voice will continue to be heard on community and broader issues.

Being a GP since 1980 and having been involved heavily in the profession in its many facets, especially in General Practice, I am distressed at the absence of GPs at the forefront of debate and representation. Personally, I believe that GPs have a unique grasp of community concerns and dreams. I would be very happy to hear from GPs who may wish to join us.

Continued Page 3

RDMA & NLMA's Joint Newsletter

Welcome from

Dr Kimberley Bondeson

President Redcliffe & District Local Medical Association

The Redcliffe & District Local Medical Association sincerely thanks QML Pathology for the distribution of the monthly newsletter.

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RDMA 2016 MEETING DATES:

For all queries contact Margaret MacPherson
Meeting Convener: Phone: (07) 3049 4444

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Wednesday	February	24th
Tuesday	March	29th
Wednesday	April	27th
Tuesday	May	31th
Tuesday	June	28th
Tuesday	July	26th
ANNUAL GENERAL MEETING - AGM		
Wednesday	August	24th
Tuesday	September	13th
Wednesday	October	26th
NETWORKING MEETING		
Friday	December	2nd

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NLMA 2016 MEETING DATES tbc:

For all queries contact Graham McNally
Meeting Convener: Phone: (07) 3121 4029
Email: gmcnally1@optushome.com.au

W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants

Time: 6.45 pm for 7.15 pm

1	February	16th
2	April	12th
3	June	7th
ANNUAL GENERAL MEETING - AGM		
4	August	9th
5	October	11th
6	December	13th

Next Meeting Date 24th February 16

Dr Robert (Bob) Brown's President's Report continued

With this in mind, we will re-develop our website and keep it current. We hope to have more local news and points of view and we will encourage input from our membership.

I would like all reading this letter to consider whom they can approach to join us. Please consider as well those who may wish to look towards leadership in the profession.

Dr Zappala has been keen to teleconference the LMA's and I wish to support this. It is important that we support one another as already exists between Redcliffe and District LMA and Northside LMA.

Please give my letter your earnest consideration.

I wish all our readers health and happiness.

Robert (Bob) Brown
NLMA President

Dr Bob Brown, President Northside Local Members Association introduced the Sponsor Representatives for the night Indivior and the speaker, Dr James (Jim) Finn: Topic: Opioid Dependence, The Brain as a Chronic Disease.

Clockwise Right: Drs Kimberley Bondeson RDMA President, Dr Robert Brown NLMA Presisent and Speaker Dr James Finn. Indiviour Representatives: Jane Morgan and Louise Hume. NLMA Member nd Dr Wally Foster. Louise Hume with Carol and Larry Gahan.

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 24th February 2016**

TIME: 7 for 7.30pm

VENUE: Renoir Room - The Ox, 330 Oxley Ave, Margate

COST: Financial members - FREE
Non-financial members $30 payable at the door.
(Membership applications available)

AGENDA:
7.00pm Arrival and Registration
7.30pm Be seated - Entrée served
Welcome by Dr Kimberley Bondeson - President RDMA Inc.
7.35pm Sponsor: Neotract
7.40pm Speaker: Dr Tim Nathan
Topic: Update on management of BPH symptoms
8.15pm Main Meal, Question Time
8.40pm General Business, Dessert, Tea & Coffee

RSVP: By Friday 19th February 2016
(e) Margaret.macpherson@qml.com.au (t) 0413 760 961

INSIDE THIS ISSUE:

AMAQ BRANCH COUNCILLOR REPORT
North Coast Councillor Report
Dr Wayne Herdy

Epidemic of Black Lung Disease and Weekend Penality Rates,

EPIDEMIC OF BLACK LUNG DISEASE.
The ABC has broadcast a series of articles about an apparent increase in the number of cases of "Black lung" (anthracosis, miner's lung) in Australia. This is troubling – for two reasons.

Firstly, if the admittedly small number of cases (I think 5 new cases this year nationwide) is statistically significant, there has been a lapse in OHS standards. OK, that is a problem for coal mine operators. More broadly, it is a wake-up call for Aussie GP's. We know that Australians have almost the highest life expectancy in the world, and mostly because of good population health measures by a now-retired cohort of GP's and public health physicians. But does it mean that occupational health physicians have dropped the ball?

Secondly, the ABC has cited cases where the diagnosis was missed by the mine operator's doctors but subsequently diagnosed by another doctor in the USA who examined digitally enhanced radiographs. The "missed diagnosis" allusion is a thinly veiled slur against the integrity of one occupational physician, and potentially against all occupational physicians. But the most unkindest cut of all (yes, Shakespeare was guilty of the double superlative) is the clear statement that Australian radiographers can't read X-rays.

For this article, I did some Internet research on anthracosis and it is really quite difficult to pin down that this is a significant public health disaster. I could speculate on why the CFMEU is shouting about this one disease. I could speculate even more about why the ABC chose to put so much effort into their story. Maybe they are all just trying to be eco-vigilantes and reminding us that our reliance on coal exports is not merely an environmental hazard. Maybe. I am reminded that this is the same ABC that last year ran high-profile but unbalanced stories about statins and Seroquel prescribing in Australia (with no Australian doctors prepared to support their storyline).

At this point, I will leave it to my readers to envisage the steam coming from my ears – as it should be from yours. Australian doctors, whether GP's or radiographers or any other speciality, are among the world's best. It is scandalous that our publicly funded broadcaster should cast spurious and unfounded aspersions like this before their audiences who, if they read the story as it has unfolded before my eyes, are being asked to question the quality of their health carers. And all just to get a story that really has no factual basis. Notch up another case of irresponsible journalism to the ABC.

WEEKEND PENALTY RATES.
The Productivity Commission (a body which actually holds my well-earned respect) has published research which recommends a brake on penalty rates for weekend and after-hours work in some sectors.

The recent enquiry into the Workplace Relations Framework states in part: "Penalty rates have a legitimate role in compensating employees for working long hours or at asocial times. However, Sunday penalty rates for hospitality, entertainment, retailing, restaurants and cafes are inconsistent across similar work, anachronistic in the context of changing consumer preferences, and frustrate the job aspirations of the unemployed and those who are only available for work on Sunday. Rates should be aligned with those on Saturday, creating a weekend rate for each of the relevant industries."

Hang on. Where is the health sector? Australians have become accustomed to 24-hour petrol stations, extended-hours supermarkets and restaurants, but if there is one sector where Australians have come to assume that a service will be available to them 24/7, it is in delivery of health services.

Extended-hour clinics are the norm, 24/7 care is demanded in emergency services and expected in other health services. If it is the norm for a sector to be expected by society to be available to them at least on weekends and late into the evenings, why are we not included among the

Continued Page 6

Dr Wayne Herdy's North Coast Councillor's Report

CONTINUED FROM PAGE 5

hospitality providers as a service which has normal hours well outside the normal hours of the public service? If the government policy-makers are being asked to trim the penalty rates for some industries, why are we still expected to pay our clinic and hospital staff high rates of pay for working hours that are now just part of what our community assumes that we will do?

A small personal aside on this, if any reader is interested. A GP can charge a relatively small premium of MBS-based fees for working outside sociable hours, but the business case is simply that any higher fees are more than consumed by the higher rates of pay awarded to receptionists and practice nurses. There is no nett moiety for the owner-operator GP unless fees are charged which bear no relation to the MBS rebate.

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

Wayne HERDY,
North Coast Branch Councillor, AMAQ.

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AMAQ BRANCH COUNCILLOR REPORT
Greater Brisbane Area
Dr Kimberley Bondeson

Health Minister Questions Private Health Insurers, Medical Cannabis and Review of the Standard Diet for Diabetes, Tributes to Dr R Neilsen and Professor T Cramond

Welcome to the new year, with a new Prime Minister, and essentially a new cabinet. As this is our 5th Prime Minster in as many years, let us hope for stability for the Country and the Health System.

January saw chemists allowed to offer a $1 discount on the price of subsidised mediations, and common drugs such as a paracetamol and reflux medications were removed from the PBS. The federal Health Minister, Sussan Ley, is questioning Private Health Insurers on their pricing, of premiums, and other expenses, particularly the excessive cost of prostheses in the private sector.

The legalisation of Medical Cannabis is being put to parliament – there would appear to be some changes in the near future. The standard recommended diet for diabetes is being questioned, with new evidence suggesting that a low carbohydrate diet is more beneficial.

There is also an extremely interesting article by a team of Israeli scientists, "Personalized Nutrition by Prediction of Glycemic Responses," published in Cell. It revealed significant personal differences in postprandial glycaemic responses in individual patients. This will further change the dietary advice we give to our diabetic patients.

Dr REGINAL NEILSON MBBS FRACGP
The passing of Dr Reg Neilsen, past Medical Superintendent of Redcliffe Hospital for 22 years, and one of the original founders of the Redcliffe and District Local Medical Association is noted. He passed away peacefully on the 17/1/16.

Condolences by Cr Allan Sutherland (Mayor) made special mention of the late Dr Reginald Neilsen, a long-time resident of the Redcliffe Peninsula area and valued community member. Dr Neilsen had been Medical Superintendent of the Redcliffe Hospital for over 20 years and was described as 'a good friend to all'. The Mayor advised that Dr Neilsen was a dedicated Rotarian and on behalf of Council provided his sincerest sympathy to the family, friends and community all touched by his passing.
(https://www.moretonbay.qld.gov.au/uploadedFiles/common/meetings/mbrc/2016/338GM20160209_agenda)

PROFESSOR TESS CRAMOND
Professor Tess Cramond, founder of the Tess Cramond Multi Disciplinary Pain Clinic at the Royal Brisbane Hospital, and life member of Surf Lifesaving Qld, also passed peacefully away on the 26/12/15.

Professor Tess Cramond was recognised internationally for her contribution to the field of anaesthesia and pain medicine. She established the Multidisciplinary Pain Clinic at the Royal Brisbane Hospital in 1967 and was its director for 42 years.

Professor Cramond has held many significant positions, including dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons and president of the Australian Medical Association (AMA). She received many accolades, including the Gilbert Brown Prize, an OBE and an Officer of the Order of Australia (AO), an Advance Australia Award, a Red Cross Long Service Award and the AMA Women in Medicine Award.
(http://www.anzca.edu.au/about-anzca/anaesthesia-stories/professor-tess-cramond.html)

Both these distinguished doctors will be sadly missed by their families, and not forgotten by their colleagues for their contributions to medicine.

Sincerely Kimberley Bondeson
Branch Councillor Greater Brisbane Area

AUSTRALIAN MEDICAL ASSOC PRESIDENT
Dr Chris Zappala

Member's Updates

Dear members,

As we did not have a newsletter in January, I would like to take a moment to wish you all a belated happy New Year and thank those of you who worked through the holiday season.

2016 has been instigated with a positive start as we welcome a record number of interns to the medical profession. We now have approximately 20,000 doctors in this state. As we look towards Queensland's changing workforce needs, it is essential doctors in training are provided with the training, skills and guidance necessary to thrive in the profession.

I am glad to see the success of programs like the Queensland Rural Generalist Pathway that seek to create a diverse, skilled and able workforce.

Last year, AMA Queensland implemented our Resilience on the Run program aimed at supporting the fortitude and wellbeing of junior doctors. The program was positively received at Rockhampton Hospital, where it was piloted, and we hope to expand it to others hospitals around the state.

Programs such as Resilience on the Run are just one aspect of building a medical workforce that is skilled, confident and able to handle the stresses of the medical profession. As senior clinicians, I believe we also have a responsibility to support these young doctors through leadership, guidance and mentorship, and I encourage you to keep this in mind in your own hospitals.

Positive cultural change is imperative for Queensland Health and we must all do our part.

Beyond Resilience on the Run, AMA Queensland has implemented a number of new initiatives to better support members, engage with the community and ensure we are working collaboratively towards a healthier state and more efficient health system. This is a key reason our Association differs from employer groups, unions and pure lobbying organisations.

Our inaugural Health Hub at the Eumundi Markets offered the public an opportunity to engage with doctors in a casual and non-clinical way, and provided access to routine health tests such as BMI and blood pressure checks.

In the coming months, we plan to expand the Health Hubs to North Queensland and other community events around the state. It will include spirometry and use of the UV skin damage camera.

As we all know, many patients do not see a doctor unless there is a serious problem, allowing issues to exacerbate and become more difficult to treat.

This complacency underpins the importance of outreach initiatives such as the Health Hubs as they provide a unique opportunity to reach patients who may not have seen a GP in years, and reinforce the need for regular health checks and the critical importance of a familiar family doctor.

These initiatives are only possible with the support of members. If you are interested in volunteering or learning more about our Health Hubs, I encourage you to do so by contacting the AMA Queensland team on 07 3872 2222 or membership@amaq.com.au.

The development of Health Hubs and Resilience on the Run are direct results of member input and feedback.

Our members are our best resource to find out what's needed in the health system and our broader communities.

I urge you to raise any advocacy concerns, member initiatives or event feedback so we can continue to best represent your interests.

Sincerely,

Dr Chris Zappala

AMA Queensland President

MEDICAL MOTORING
WITH DOCTOR CLIVE FRASER
"My Aged Care - Wouldn't Be Without Them"

Safe motoring,
doctorclivefraser@hotmail.com.

After 19 years on the road it was inevitable that my beloved Volvo V70 wagon would catch a cold and break down some time. As these things happen it halted right at the entry to the carpark for my rooms. Unable to get it going again, for the first time ever, I called my Auto Club's breakdown service for help.

Their motto is, "Wouldn't be without them", and true to their word within 15 minutes their mechanic arrived.
He took a brief history, turned the ignition on a couple of times, primed the fuel pump, and then presto I was back on the road. It's very comforting to know that for $86 per year wherever you are, help is always at hand. I'd estimate that a 19 year old car is pushing the equivalent of 95 human years, so I treat the old girl with a lot of respect and tender loving care.

Just the way you might support an elderly member of the family still living at home. But with health problems surfacing for an elderly relative I have some concerns about the complexity of accessing help for your beloved. For starters there's a thing called My Aged Care.

I understand that by the time you read this article it will have replaced ACAT which I had no previous complaints about. There was a 45 minute phone call to take the details and a faxed copy of an Enduring Power of Attorney verified that I was authorized to act on behalf of the relative. All's well and good, so far. Then there was an appointment for an assessment lined up.

But the assessor was a no-show and it took 4 days to track her down upon which she advised that the assessment was next week and not last week, even though that wasn't what she had said and verified in her text message. Not wanting to bite the hand that feeds you, we met subsequently and from then on things went further astray. There was a text message from her on a Saturday afternoon and a phone call on a Sunday morning.

Unfortunately, the assessor by this point had said she'd assessed the husband, when it was actually the wife. Oh, by the way, she also failed to identify that there were cognitive problems which were the original reason for the referral in the first place. Easily sorted, but then you are asked to wait for a call from a care provider.

Days turned into weeks and eventually a call back to My Aged Care shed more light on the lack of progress as the assessor had not "issued" the request to any care providers.

All sorted again and copious apologies from the call centre. On track at last, but then another phone call from someone else at My Aged Care offering to assess the applicant. I'm always happy to accept help, but hadn't that already happened. Finally, after 8 weeks of frustration the care providers started to call. But the advice was, "You'd be better off with a package".

Against the odds I called ACAT directly, explained the situation and asked for help. No hold-ups this time and everything about their recommendations was put in writing. Throughout all of this my elderly relative kept asking, "How do people cope who don't have any friends or family to help them?" I would ask exactly the same question.

Friends and family, "Wouldn't be without them".

Safe motoring,
Doctor Clive Fraser

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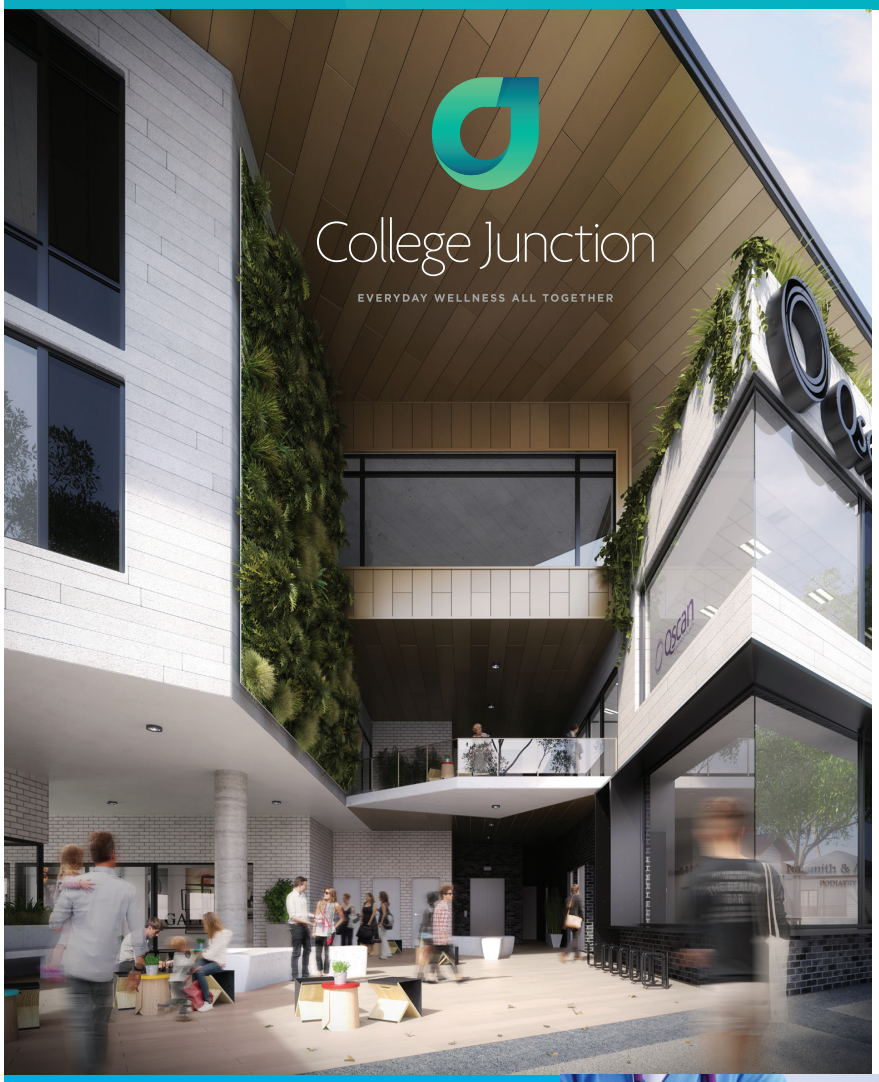

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Computers & Gadgets
with Doctor Daniel Mehanna
"Smart Watch Or Dumb Idea?"

Technology is a funny thing. It is constantly changing, evolving and progressing. Gadgets get faster, smaller, better. Great new revolutionary products (such as the iPhone) open up new markets solving problems we didn't even know existed!

But sometimes things don't go as planned. Sometimes despite vast amounts of research and development and of course clever marketing, a product just doesn't hit the spot. But why does this happen? Perhaps the product is before its time or possibly just not mature and polished enough to be released. Whatever the reason, the product just doesn't catch on.

Being an early adopter myself, I have to admit when smart phones were released a few years ago I was initially sceptical. I scoffed at those with their flashy smartphones, wondering why they thought themselves to be so important that they couldn't check their email at their desk instead of on the bus. I laughed at their phone's pitiful battery life. But once I joined their ranks, I never looked back.

It is with this in mind, I finally decided to put all my preconceptions aside and give a smartwatch a try. My Dad had recently acquired a smartwatch and suggested I try his out. He had bought an LG G Watch R. As far as smart watches go, the G Watch R is actually quite nice to look at. It has a traditional round design with a leather strap that actually looks like a watch instead of a looking like a ipad mini strapped onto your wrist. On the negative side however, I found it rather large and thick. Having said that, it was quite wearable and didn't look dorky or like something you would expect to see on the bridge of star trek. So far so good then.

So having charged the little guy up, updated the software and linked it to my phone I was all set. The first thing I did (like many others) was to download a whole bunch of watch faces. From classic to modern to funky and sporty... the watch face could be fully customised with minimal fuss. I could even download and install super expensive watch faces from Rolex and the like. A "Rolex" for a couple hundred dollars... not bad! After that I headed online and did a little research in what "killer apps" I should be installing on my new phone then headed to the play store and downloaded a few. I was then all set to go. For the next month I was to wear my new friend every day to see what all the fuss was (or perhaps wasn't) about.

The first thing I learnt was that it was next to useless without being paired to my mobile via Bluetooth. So this meant my mobile had to be within a few metres of it pretty much all the time. This was not a big deal at work, but not ideal at home. If I was charging my phone in one room and was wearing my watch around the house they would become disconnected. The other problem was that now my phone's bluetooth had to be switched on all the time, which would suck the phone' battery life.

The second thing I also learnt was that it also (along with my phone) needed to be charged every day. Not the end of the world as I would charge it at night when going to bed. But these problems would be tolerable, I reasoned, if the smart watch was useful. So what could it do.

Well it got me a little attention for one thing. For the first few days, I would be questioned by colleagues about my new toy and would somewhat apologetically explain that I was trying it out and wasn't really a geek! Upon being asked what it could do, I would show them a few watch faces which would be enough. Could I use it to make a phone call and have a conversation, I would be asked. Unfortunately not, as the watch was not manufactured with a speaker (don't ask me why). Having said that, the newer generation of watches now have speakers.

One of the most useful features, I found was call notification. If I received a call on my mobile, my Smart Watch would alert me of the call with the person's name on the screen accompanied with a vibration. I could then reach for my phone and

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CONTINUED FROM PAGE 12

answer it or choose to decline the call and send a pre-programmed SMS back to the caller (such as "I'll call you later").

The other thing I could do was to send and receive SMS (and emails) to contacts, but again, these had to be pre-programmed SMS as I could not type on the watch screen. Alternatively, I talk speak to the watch and send a spoken SMS message to them (not so handy in a meeting!). It was also able to function as a fitness monitor but admittedly I did not try this out.

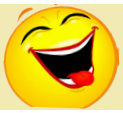
With the help of third party apps I was also able to install a keyboard on the phone which I found impractical and fidgety due to the small size of the keyboard. There also was an app to install a web browser on the watch, which I have to admit, I did not even try as I thought it would be pointless due the watch's small size. It would make more sense to use my phone instead.

But the more I thought about it and used my smart watch, the more I came to the same conclusion that even Apple has admitted. The function of the smart watch is to "liberate" us from having to check our phone all the time. So, let me get this straight. Apple designs a smart phone, gets us all addicted to the point of making us self absorbed robots, then says there is a solution... which is, wait for it, another gadget! And the Smart watch is born!

But in the end, no matter just how hard I tried, I just couldn't get it. At the end of the day, the watch did nothing more than my smartphone. In fact, the best thing about my smart watch (as I usually don't wear any watch), was that it saved me having to take out my mobile from my pocket to tell the time!

Daniel Mehanna

Interesting Tidbits NATTY MOMENTS:



Q: Why didn't the skeleton go to the dance?
A: Because he had no-body to go with.

Q: Did you hear about the angry pancake?
A: He just flipped.

Q: What do prisoners use to call each other?
A: Cell phones.

Q: What do you call a cow with a twitch?
A: Beef Jerky.

Q: What Do You Call A Bear With No Teeth?
A: A Gummy Bear

Q: What do you get when you cross Sonic The Hedgehog and Curious George?
A: 2 Fast 2 Curious

Q: What do you call a musician with problems?
A: a trebled man.

Q: Did you hear about the Italian chef that died?
A: He pasta way.

Q: Where do snowmen keep their money?
A: In snow banks.

Q: Did you hear about the crab that went to the seafood disco?
A: He pulled a muscle

Q. What did the tie say to the hat?
A. You go on ahead and I'll hang around

Q: What washes up on very small beaches?
A: Microwaves!

Q: What goes through towns, up & over hills, but doesn't move?
A: The road!

Q: Did you hear about the guy who got hit in the head with a can of soda?
A: He was lucky it was a soft drink.

Q: Why was there thunder and lightning in the lab?
A: The scientists were brainstorming!

Q: Why did Tony go out with a prune?
A: Because he couldn't find a date!

Q: Did you hear the one about the geologist?
A: He took his wife for granite so she left him

Q: What did Winnie The Pooh say to his agent?
A: Show me the honey!

Q: What did the man say to the wall?
A: One more crack like that and I'll plaster ya!

Is your practice ready for the Fair Work Ombudsman audits?

Private practitioners should be aware that the Fair Work Ombudsman (FWO) has started a new education and compliance campaign in the health care and social assistance industries, which commenced in December 2015. The campaign has been developed in consultation with key stakeholders including the AMA, and focuses on raising industry awareness of Australian workplace laws, providing education on these obligations where needed and improving compliance within the industry.

In the last three financial years, the FWO has taken the following actions against employers in the health care and social assistance industries:

- 43 formal letters of caution regarding workplace practices were issued to employers;
- Seven matters were taken to court for prosecution; and
- Eight employers received on-the-spot fines for infringements.

The FWO has indicated that the focus of the campaign is to ensure employers of reception and administrative staff in general practice and specialist practices are meeting their wage rate and record keeping obligations. It is estimated that around 200 medical practices will be assessed by FWO inspectors.

Practices that are selected by the FWO to participate in the campaign will be directed to provide employee time and wages records for a recent pay period. Where an employer has more than 25 employees, they will be requested to provide a representative sample of no fewer than 10 employees. This sample should include (where applicable to the practice) a range of different employee classifications and employment types (full-time, part-time and casual) and must include all 457 visa employees.

The time and wages records for the selected recent pay period will need to specifically include the following information:

- Payroll advice records or pay slips which clearly state amounts paid to employees, including base hourly rates of pay (or salary), loadings, penalties and allowances;
- A sample payslip, which the FWO will assess against the payslip requirements prescribed in the Fair Work Regulations 2009. Compliance with payslip requirements will be one of the main areas of focus during the campaign, and FWO inspectors will have the discretion to issue on-the-spot fines for breaches;
- Attendance records (i.e. time sheets and rosters) showing hours worked by employees, including any overtime;
- Records of any hours where employees attended training sessions or staff meetings *(note: inspectors will be looking to see that employees are being paid for these meetings if they are held outside an employee's ordinary working hours)*;
- Copies of any Individual Flexibility Arrangements (IFAs) made with employees; and
- Copies of any apprenticeship or traineeship agreements.

Did you know - AMA Queensland members receive complimentary advice and support regarding the FWO audits. Should any members be contacted by the FWO regarding the campaign and require assistance from AMA Queensland, they can contact the Workplace Relations Department on (07) 3872 2222. Not a member of AMA Queensland? Join now to access our free support workplace relations services and ensure your practice is compliant with the Fair Work Regulations: https://ama.com.au/join-renew

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Meet Our Team

Dr John Reardon
Medical Oncologist/ Clinical Haematologist
*SC

Dr Hong Shue
Medical Oncologist
*SC

Dr Sorab Shavaksha
Clinical Haematologist
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Jesse Goldfinch
Excercise Physiologist
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Dr Rosanne Middleton
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Medical Oncologist Palliative Medicine Specialist
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Haematologist/ Oncologist Paediatric Haematologist
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Tania Shaw
Oncology Massage Therapist
*SC

Dr Raluca Fleser
Clinical and Laboratory Haematologist
*NL

Dr Geoff Hawson
Medical Oncologist Clinical Haematologist Palliative Care Physician
*NL

Be Our Guest

Sunshine Coast Haematology and Oncology Clinic is delighted to be supported by the McGrath Foundation through the provision of the McGrath Breast Care Nurse, who is available to help community members and their families through breast cancer by providing free advice, support and care when it's needed most.

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7 Endeavour Bvd, North Lakes Q 4509 (next to OzCare)

Sunshine Coast Haematology and Oncology Clinic
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10 King Street, Buderim, 4556

ALTRUISM, EUTHANASIA AND DOCTORS

By Dr Mal Mohanlal

In altruism, a person directs his or her activities towards the welfare of others. It is considered to be a selfless action, but if we examine it closely the self or the ego is always involved. This is because helping other people, whether it is benefiting the other person or not, always makes one feel good. You may not be aware of it, but please understand that this is a conditioned response in our subconscious mind when we are helping others.

Altruism is thus found in many professions, but one cannot deny the fact that doctors, nurses and religious missionaries must be regarded as front runners. This is because people who enter these professions are genuinely out there to do some good in society and at the same time feel good about themselves. Hence we find the greatest collection of do-gooders and ego-trippers gathered under the sun in the medical profession. Undoubtedly doctors are mostly nice obliging fellows, always willing to help their patients. These chaps find it difficult to say no to their patients because they subconsciously feel bad if they said no. This is why many of us are taken for a ride by our patients simply because it does not occur to us to say no.

However, there is one exception to this rule, and that is euthanasia. In this case most of us will say no because actively taking a human life, no matter what the circumstances makes us feel bad. It is easier to keep a person alive and make oneself feel important rather than help a dying suffering patient go to sleep permanently. In this we use the law of the land as a good excuse to hide behind, as many of us do not want to feel bad.

A few years ago I visited a patient of mine in a palliative care unit of a local hospital where he was dying from throat cancer. He had intravenous tubes attached to him and had a naso-gastric tube down his throat. One could see that he was dying and in pain and was wasting away from starvation. Sitting beside his bed I could see all the doctors and nurses looking very important and busy doing their jobs. He pleaded with me to ask the doctors to put him to sleep permanently. I said, “Do you know that if we obliged you, all these people would be out of a job”. He quietly understood and accepted the reality of the situation.

Hence it would be wishful thinking for anyone to think that the medical profession would accept euthanasia as a means of peaceful exit from this world in the near future. The livelihood of a doctor depends on his patients. So I do not think that any doctor would be in a rush to cut down his living this way even though there is a moral obligation for him or her to do so. Therefore, is legalising euthanasia the answer? Please observe and think. Anything we legislate is always exploited by the ego. If we give an inch, the ego always wants to take a foot. That is the nature of the beast. Clearly, anything we legislate is open to abuse by unscrupulous individuals amongst us, no matter how well meaning our intentions might be. If we legalise euthanasia we will be surely creating more problems than we will be solving.

In the olden days when doctors were practicing medicine in the traditional way, there was a direct bond established between a doctor and a patient, and euthanasia would not have been an issue. The doctor would have treated the patient in a humane and compassionate way. Now however, in this consumer society where there are consumer laws and litigation to deal with, our value system has changed. It has destroyed this true doctor-patient relationship. The laws have inculcated doctors into treating patients as consumers and as a consequence both the doctors and the patients have become the losers. The doctors cannot treat patients as they should be treated and the patients cannot be treated as they would want to be treated. They are kept alive under all circumstances no matter what quality of life may be waiting for them.

So what avenues would terminally ill and dying patients have to put themselves out of misery? Apart from depending on the medical profession to keep them comfortable or taking drugs that can relieve their suffering, there is not much one can do. Most of us if we were in that situation would be too weak to drag ourselves out into the snow. However, all is not lost. As I see it, those in this terminal situation who possess some insight into their mind and have retained some capacity to think, can still use the power of their subconscious mind to exit this world peacefully. All they have to do is to understand the fact that death is a just a beautiful sleep from which one never wakes up. It is an eternal sleep.

In my book “The Enchanted Time Traveller-A Book of Self-Knowledge and the Subconscious Mind”, you will find a chapter on Insomnia where you train your subconscious mind to help you to go to sleep naturally. You should study it and learn how to go to sleep naturally. If you are terminally ill and wish to exit this world permanently, all you have to do is to change the instructions I have given at the end regarding waking up. You will be amazed and pleasantly surprised to find that once you understand how you can go to sleep naturally all your fears about death and sleep will ease and disappear.

Please never become despondant. You should learn how to use the power of your subconscious mind to help you in all circumstances and write your own destiny. If you don’t, then your destiny will be already written for you.

Visit website: http://theenchantedtimetraveller.com.au/

AGED CARE CONVERSATIONS

With about 75% of people over 65 on some kind of government pension, the Age/Service Pension provides 'bedrock' income for many retirees. As such, a high priority for many retirees will be discussions around changes to the Age Pension rules and recent changes to Australia's Aged Care system. Like the changes that commenced on 1 July 2014, the Aged Care changes are likely to increase the contribution an aged care recipient makes towards the cost of their care.

From 1st January 2016, "new Aged Care residents" will have the rent they receive from their former home assessed under the Income Test for aged care purposes regardless of whether they are paying a Daily Accommodation Contribution (DAC) or a Daily Accommodation Payment (DAP). A "new Aged Care resident" is defined as one whom enters residential aged care on or after 1st January 2016. If they change their facility it will not affect the resident's ability to claim the exemption where they were not out of residential care form more than 28 days during the transfer.

So whilst this rule surrounding the former home changes for Aged Care services, both the rental income and the value of the home will continue to be exempt when determining Aged Pension entitlements. However, if a pensioner leaves their principal home and enters a care situation, their home may be exempt from the assets test for up to 2 years.

Changes are aplenty for Pensioners, the Assets Test threshold and Aged Pension qualifying ages taper will commence on 1st January 2017. The table below illustrates these changes and most pensioners will be affected in some way.

Age Pension Asset Test threshold	Legislated threshold for full Age Pension	Estimated cut-off threshold
Single, homeowner	$250,000	$547,000
Single, non-homeowner	$450,000	$747,000
Couple, homeowner	$375,000	$823,000
Couple, non-homeowner	$575,000	$1,023,000
Couple, illness homeowner	$375,000	$969,000
Couple, illness non-homeowner	$575,000	$1,169,000

Source: https://www.liberal.org.au/latest-news/2015/05/07/fairer-access-more-sustainable-pension. Estimated amounts are based on projected rates and thresholds as at 1 January 2017.

The complexity of all these rules and regulations are forced upon them when all of a sudden for many reasons, an older Australian needs an ACAT assessment. The ACAT assessment will help to determine the range of care options that they have available to them being, independent living, serviced units or an Aged Care facility.

This can be a point for family stress to really bite, as a Means Tested Amount (MTA) needs to be calculated to determine the client's affordability for accommodation payments and daily care fees at Aged Care facilities. The MTA also determines how much the government pays for the older Australian.

Both Don Poole and Kirk Jarrott are Accredited Aged Care Professionals who can help create family solutions and help families make informed decisions during difficult times.

If you would like to discuss this article please give either Don or Kirk a call on 07 54379900.

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AMA

FEDERAL CUTS RESULT IN FUNDING 'BLACK HOLE' FOR AUSTRALIA'S OVER-STRESSED PUBLIC HOSPITALS AMA Public Hospital Report Card 2016

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA's latest snapshot of the performance of Australia's public hospitals points to an imminent crisis as the effects of Federal funding cuts make it harder for hospitals to meet growing patient demand and to reach significant performance benchmarks. The AMA Public Hospital Report Card 2016, released today, shows that, against key measures, the performance of our public hospitals is virtually stagnant, and even declining in key areas.

AMA President, Professor Brian Owler, said the disappointing results are a direct consequence of reduced growth in the Commonwealth's funding of public hospitals, and things will get much worse in coming years unless the Commonwealth reverses its drastic cuts from recent Budgets. "The States and Territories are facing a public hospital funding 'black hole' from 2017 when growth in Federal funding slows to a trickle," Professor Owler said.

"From July 2017, the Commonwealth will strictly limit its contribution to public hospital costs. "Growth in Commonwealth funding will be restricted to indexation using the Consumer Price Index (CPI) and population growth only. "Treasury advised the Senate Economics Committee that this change will reduce Commonwealth public hospital funding by $57 billion over the period, 2017-18 to 2024-25. "As a result, hospitals will have insufficient funding to meet the increasing demand for services.

"In the 2015-16 Budget, Commonwealth funding for public hospitals was reduced by $423 million for the three years to 2017-18. A further $31 million was cut in the December 2015 MYEFO Budget update. "Public hospital funding is about to become the single biggest challenge facing State and Territory finances – and the dire consequences are already starting to show. "Bed number ratios have deteriorated. "Waiting times are largely static, with only very minor improvement. "Emergency Department (ED) waiting times have worsened. "The percentage of ED patients treated in four hours has not changed, and is well below target. "Elective surgery waiting times and treatment targets are largely unchanged. "Public hospital performance has not improved overall against the performance benchmarks set by all Governments. 2

"On top of all that, the Commonwealth is creating additional and unnecessary demand for hospital services by reducing Medicare payments for diagnostic services in the community by $650 million. "These services are essential to diagnosing and treating people early to keep them out of hospital." Professor Owler said the Commonwealth Government continues to retreat from its responsibility in regards to public hospital funding arrangements with the States and Territories. "There is no greater role for governments than protecting the health of the population," Professor Owler said. "Public hospitals provide essential healthcare services across the community. "The dedicated and hardworking doctors, nurses, and other healthcare practitioners who work in public hospitals continue to provide Australians with world class health care. Their professionalism means they are doing more with less.

"Public hospitals are the foundation of our healthcare system. "They are the training ground for the future medical workforce. "They are the safety net for the people who can't afford private health insurance. "They are the places where extraordinary gains in medical science are developed to constantly improve patient outcomes. "Public hospital funding and improving hospital performance must be a priority for all Australian governments," Professor Owler said.

Key findings from the AMA Public Hospital Report Card 2016 include:

- hospital bed to population numbers have remained constant over recent years, while there has been increasing demand for hospital services;
- nationally, only 68 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes; and
- in 2014-15, no State or Territory met the interim (2014) or final (2015) National Emergency Access Target of patients being treated within four hours. Performance in Victoria and Western Australia was below their 2013 targets, and performance in South Australia, Tasmania, the Northern Territory and the ACT was below their 2012 targets, with the Northern Territory performance in 2014-15 failing to meet their baseline for this target.

The AMA Public Hospital Report Card 2016 is available at https://ama.com.au/ama-public-hospital-report-card-2016

The AMA Public Hospital Report Card 2016 was compiled using information from:

- Australian Institute of Health and Welfare, Australian Hospital Statistics: Hospital resources 2013-14; Australian Hospital Statistics 2014-15: emergency department care; Australian Hospital Statistics 2014-15: elective surgery waiting times; Health Expenditure Australia 2011-12, 2012-13 and 2013-14.
- Commonwealth Budget documents, Budget Paper No. 3 2013-14, 2014-15 and 2015-16; and Mid-Year Economic and Fiscal Outlook (MYEFO) 2012-13, 2013-14, 2014-15, and 2015-16.
- Council of Australian Governments (COAG) Reform Council, National Partnership Agreement on Improving Public Hospital Services: Performance Report for 2013 (NEAT and NEST targets).

28th January 2016

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Immigration and Immigrant Ships
Moreton Bay Part III Colonists From Germany Continued.

https://espace.library.uq.edu.au/view/UQ:241112/s18378366_1935_2_6_304.pdf

Artemisia from illustration by Frederick Smyth in the Illustrated London News, 12 August 1848

Colonists from Germany Continued

On a previous occasion six years earlier, on March 14, 1855, two small German barques had arrived in Moreton Bay almost simultaneously with immigrants. One of these, the "Merbz," brought out 270, and the other, the "Aurora," 236. The latter, unfortunately, went ashore on Moreton Island and became a total wreck, but all the crew and passengers were safely landed. The disaster was due to the fact that the captain had no chart and was under the impression that the south entrance was the only way into the bay. On realising the hopelessness of his position he ran the vessel with square yards on to the beach. The "Grasbrook," the "Johann Caesar," the "Caesar Godeffroy," the "Iserbrook," and the "Helene" also brought out colonists from Germany prior to 1860.

First Black Ball Liners.

The ship "Wansfell," of 770 tons, which arrived in Moreton Bay on November 10, 1861, with 300 immigrants, was announced as being the first Black Ball liner to come out under the company's agreement with the Queensland Government. But the ship "Montmorency," which was owned by the Black Ball line, had arrived on October 16 of the previous year with 310 new people. Both the "Wansfell" and the 314 "Montmorency" were well-built and shapely vessels, launched from British North American shipyards in 1853 and 1854, respectively. They both had been bought by Mr. James Baines practically off the stocks, and both had made voyages to Sydney and Melbourne with immigrants before their first visit to Queensland waters.

The "Montmorency" was brought to Moreton Bay in 1860 by Captain David M. Bridges who, however, died in Brisbane from filaria. The chief officer took the ship to Newcastle, where she loaded coal for Hongkong. On her next outward voyage she dropped anchor under the lee of Moreton Island on April 8, 1862, being then commanded by Captain J. T. Sowerby, She loaded wool in the bay for London, and on her homeward passage had the most sensational experience of her career. She got among icebergs in southern latitudes, and later encountered gales of unparalleled ferocity, in which she was badly dismasted.

While in this helpless condition she narrowly escaped being cast on the rocks near the dreaded Cape Horn. In April, 1863, under Captain Maxwell, the "Montmorency" left Liverpool with 400 immigrants for Hervey Bay (Maryborough), but she put into Moreton Bay on July 17, and landed her passengers there, instead of going on to Hervey Bay. Early in 1866 the "Montmorency" took another lot of prospective settlers to Bowen, and the records show that Captain Jas. Cooper, who was in charge, had a particularly trying time on the way out. It is said that the captain and his oflflcers kept loaded revolvers within reach day and night, and that it was only by the adoption of such stern measures that a mutiny was avoided. From Bowen the "Montmorency" came to Moreton Bay and loaded a wool cargo for London.

In December of the same year she left London for Napier, New Zealand, with immigrants, and arrived safely on March 24, 1867. All the passengers were landed there but, on the following day, a fire mysteriously broke out and the ship was burned to the water's edge.

The "Flying Cloud."

The "Flying Cloud," to which passing reference has already been made, was one of the most famous of the Boston-built clippers. She was added to the Black Ball fleet in 1862; and at once put into the Queensland immigration service. Altogether the "Flying Cloud" made six voyages to Moreton Bay and one to Maryborough. She was sold in 1870, and four years later went ashore on the coast of New Brunswick, near St. John. She was floated off and towed into harbour. But the hand of Fate was upon her, for while she was on a patent slip for repairs, a fire broke out and she was so badly damaged that there was nothing for it but to break her up.

Continued Next Month