RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
JUNE 2016

General Practitioners Liaison Officer Updates #1

Contact for Dr James Collins, GPLO. james.collins2@health.qld.gov.au.

WHAT'S NEW AT REDCLIFFE HOSPITAL?

See Where We Work & Live on page 20.

President's Report Dr Kimberley Bondeson

We are now again in election mode, with the federal election set for July 2nd, 2016.

Are we in for another new Prime Minister? I have forgotten how many we have had over the last 5 years. And another Federal Health Minister too?

I have had to take the question "Who is the Prime Minister of Australia" out of the Mini Mental State Exam, as with the political changes, it is not reasonable for some of our patients to know who is the current Prime Minister.

The only good news is that at least Australia does not have the very prolonged process of campaigning like the United States of America has.

Winter is finally here, after our long, hot summer and with it has come some incredible storms, which have been battering the Australian Coastline. Our thoughts go out to those whose homes have been affected, and continue to be affected in NSW. Watching the community rally together to try and protect some of those houses with sandbagging was inspiring, and reminds us all what we can do together as a community.

The Redcliffe Peninsular is extremely protected, with Morten Island protecting the coastline and dulling some of the strong winds which are forecast. However, it has not stopped the flash flooding which has occurred all over Brisbane and its surrounds.

I recently spent the weekend at the AMA National Conference in Canberra, which was interesting to say the least. We have a new AMA President, Dr Michael Gannon, and AMA Vice-President, Dr Tony Bartone. I wish them well in their new roles, they have a hard job ahead of them.

I was saddened to hear at the Conference, that last year 40 medical graduates missed out on Internship placements in Australia, and that this is going to continue to get worse.

Queensland still relies on 60% of it medical workforce from International Medical Graduates, so there seems to be a discrepancy in the system – which we have been aware of, and have been telling the government for years that the direction they were taking, with opening up new medical schools, and insufficient training positions and internship places, would result in new graduates being unable to obtain full registration.

Kimberley Bondeson
RDMA President

RDMA & NLMA's Joint Newsletter

Welcome from
Dr Robert (Bob) Brown

President Northside 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
Wednesday	May	25th
Tuesday	June	28th
Tuesday	July	26th
ANNUAL GENERAL MEETING - AGM		
Wednesday	August	24th
Tuesday	September	13th
Wednesday	October	26th
NETWORKING MEETING		
Friday	December	2nd

RDMA NEWSLETTER DEADLINE

Advertising & Contribution 15 July 2016
Email: RDMANews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

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 28th June 2016

25.05.16 Dr Kimberley Bondeson, President Redcliffe & District Local Members Association introduced the Bayer Sponsor Representative for the night Mr Damien Walker, Manager.

Bayer Sponsored the speaker for the night. Dr Scott McKenzie, Topic: 'Not clotting, not bleeding and stopping it all in a hurry: Anticoagulation and Cardiogenic Shock".

Below Top Down:
1. Speaker Dr Scott McKenzie
2. Bayer Reps; Ian Adams, Jacqui Marler, Damien Walker -Manager and Brendan Craig.
3. Ian Adams, Jacquie Marler, Scott McKenzie, Damien Walker and Brendan Craig.

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 28th June**

TIME: 7 for 7.30pm

VENUE: Regency 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: Iconcore
7.40pm	Speaker: Dr Michelle Jalilian
	Topic: Breast and Skin Cancer a General
8.15pm	Practitioner Overview
8.40pm	Main Meal, Question Time
	General Business, Dessert, Tea & Coffee

RSVP: By Friday 24th June 2016
(e) Margaret.macpherson@qml.com.au (t) 07 3049 4444

INSIDE THIS ISSUE:

AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

REPORT OF AMA NATIONAL CONFERENCE 2016

Your respondent spent a weekend in Canberra as a Queensland delegate to the 2016 AMA National Conference.

PRESIDENT'S ADDRESS, key messages.
The government has a history of change without consultation, which taxed the relationship between medical lobby groups and the former Minister. The relationship changed dramatically when Peter Dutton handed the portfolio over to Sussan Ley, who has a far more consultative approach. She still has no more money in the coffers, but at least she is listening to health providers who should understand the field. The Medicare freeze was imposed by Treasury, not by the Minister for Health. But there is an emerging awareness among patients that it is their rebate, not the doctor's rebate.

The AMA agrees with the MBS review of rebates, but deplores the public rhetoric that this is necessitated by the greed of doctors. Vilifying doctors will not encourage meaningful dialogue in this area. The AMA remains the leading and most respected lobby organization in the Parliamentary environment.

SPEECH BY Hon CATHERINE KING, member for Ballarat, Shadow Minister for Health, to the National Conference of AMA in Canberra 27th May 2016. As expected, the Shadow Minister focussed on the ALP health platform in the coming election. She states that, for voters, health is the number one issue, above voters' concerns about the economy. This encouraging, because it is not (yet) what we are seeing in the media.
1. Labor's vision is to increase Commonwealth intervention, to strengthen primary care, to enhance integration between health sectors.
2. Health of asylum seekers rates high priority. The ALP will maintain the position of the Chief Medical Officer of Border Force, with an intent to increase the transparency of health care, and to maintain best medical practice on Manus and Nauru [she assumed that Manus and Nauru will survive through the next term].
3. Labor oppose privatisation of some aspects of health care (she specifically expressed concern that Telstra will operate a health programme that will give them access to patients' information about Pap smears and bowel screening programmes).
4. Labor will unfreeze Medicare rebates and restore indexation. Labor believes this reflects the importance of primary care. They recognize that (at least) 1 in 20 patients delay seeking health care because of costs, and 1 in 8 scripts are not filled because of costs.
The Shadow Minister took some pride in making what she described as the third major health announcement of the election campaign. Referring to the "boom and bust" cycle of health policy, with inconsistent piecemeal policy changes, she said that we need to embed a policy system that tolerates mistakes and survives the electoral cycle and changes of government. She announced Labor's intent to create a permanent Health Care Reform Commission, accountable to COAG, and intended to restore some functions of offices abolished by the present government. The idea is to create some consistency in health policy over long periods of time. This proposal was disparaged later in the morning as "nebulous", but wouldn't it be wonderful if the health sector could look forward to some degree of predictability in development of health policy?

SPEECH BY Dr RICHARD DI NATALE, Senator representing Victoria, leader of the Greens, to the National Conference of AMA in Canberra 27th May 2016. The underlying theme of the Greens' health platform is that health is an investment, not a cost, is not unsustainable despite an ageing population, and reflects community support for increasing health expenditure. [He said Australia spends 9% of GDP on health costs, compared with OECD averages of 11% and USA estimates of 17% of GDP.]

The Greens support the enrolment of patients at least for chronic disease management. For CDM, he supports increased access to allied health personnel [but we did not get a view of how this fits into the EPC programme].

Of particular interest to me, he advocates specific increases in opioid treatment programmes. Despite the fact that he has a background as an addiction practitioner, he **Continued Page 6**

Dr Herdy's Report continued
from page 5

proposed increased funding of $10 million. With due respect, he got the decimal place wrong – that sum of money would probably look after the Sunshine Coast where I work, but would be a drop in the ocean in addressing drug and alcohol abuse nationwide. He was prepared to stick his neck into controversial territory by declaring the Greens' support for end of life decision-making, leaving the final decision to individual practitioners. [In my view, he overlooked the reality that most doctors do not want to get involved in end-of-life decisions, let alone end-of-life interventions.]

As expected, he spoke, albeit briefly, about climate change and derided the "institution" of mandatory detention. He declared war on antibiotic resistance and supported a tax on soft drinks and volumetric taxation of alcoholic beverages.

SPEECH BY THE HON SUSSAN LEY, MEMBER FOR FARRER (Albury), MINISTER FOR HEALTH to the formal dinner of National Conference of AMA in Canberra 28th May 2016. The Minister broke with a long-established tradition of delivering the first major speech of National Conference. Maybe she feared the very public response she was going to get from a hostile AMA audience, but she reserved her attendance to the gala dinner conducted on Saturday night, a private event that is not usually covered by the public television stations. This was a politically risky strategy, to give your opponents first exposure to the audience, and allow them early access to the AMA media room with no reply from the Minister, and have no public appearance at the peak medico-political function of the year, only a month before a federal election.

The Minister devoted most of her speech time to negative responses to the other two leaders who had spoken the day before. And she was well briefed on details of their speeches. She described the ALP policy as a step back in time, to create a huge new bureaucracy and take an axe to clinician-led reform.

There were a few positives. She derided chequebook policy as a source of bad policy. She affirmed that health spending is growing faster than inflation, which is unsustainable. She insisted that health budgeting should be central to any economic debate.

Finally arriving at Coalition policy, she started with the MBS review, which she described as being aimed to make health spending more contemporary and delivering better value for money. Fine words, but let's wait with bated breath for the final product.

She finally reached a crucial policy, the "health care home". While the health care home is intended to enrol only 20% of patients with a primary care provider, those with chronic disease management, it only offers a cash handout of $322 per patient. Not much of a carrot for GP's, but promises to be more sensible than the current EPC arrangement. However, this is blatant enrolment and opens a very wide door to introduce capitation. Capitation is still a dirty word in AMA circles, but I was disappointed to see signs of approval among some present.

She skipped on to hospital funding. Coalition policy is based on increased expectations from the States, decreased funding for unsafe care (however that is going to be managed), and reduction in avoidable admissions.In question time, our members were remarkably restrained and polite. Nobody mentioned the Medicare freeze – it was like Fawlty Towers and "don't mention the war." The closest we came was a question on co-payments: the answer "if it becomes political, it is unlikely to happen" so the Minister advised the AMA to turn it into a bipartisan issue and then it would receive consideration.

POLICY IN AN ELECTION YEAR

We heard from four renowned journalists with their predictions about the likely outcome of the election, with some reasoning behind their conclusions. Although at the time of writing I am still not seeing it in the media, they unanimously declared that health had taken over as the number one issue for voters, ahead of the economy or the personalities of the candidates. Various strategies and contentious topics were discussed, albeit with little of substance to report back to my readership.The enduring message for the profession was a little unexpected for me. With the announcement of the proposed Medicare freeze, we observed a barrage of outcry from the AMA, the various Colleges, and every medico-political body in the country. The journos thought this was the first time that they had ever observed the profession to be united in supporting bulk billing.

MEDICAL SELF-REGULATION – DIAGNOSIS, PROGNOSIS AND TREATMENT.

The panel in this discussion unfortunately did not address an underlying question of whether the profession should be allowed to self-regulate. Most of the time was devoted to the question of re-accreditation, or the in term is now "re-validation". Dr Joanna Flynn, Chair of the Medical Board of Australia, opened with a view that the existing systems are collectively not enough. We need to ask the Colleges (a) is what their members are doing truly relevant to their practice? And (b) are you confident that your accreditation system is the best is can be?

A/Prof Matthew Thomas **Continued Page10**

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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
***SC**

Jesse Goldfinch
Excercise Physiologist
***SC**

Dr Rosanne Middleton
Clinical Health Psychologist
***SC**

Dr Peter Davidson
Consultant Haematologist
***NL**

Dr Kieron Bigby
Medical Oncologist
***NL**

Sarah Higgins
Dietician/ Nutritionist
***SC**

Dr Darshit Thaker
Medical Oncologist
Palliative Medicine Specialist
***NL**

Dr Lydia Pitcher
Haematologist/ Oncologist
Paediatric Haematologist
***SC**

Tania Shaw
Oncology Massage Therapist
***SC**

Dr Raluca Fieser
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.

North Lakes Haematology & Oncology Clinic
Tel: (07) 3833 6755 | www.nlhoc.com.au
7 Endeavour Bvd, North Lakes Q 4509 (next to OzCare)

Sunshine Coast Haematology and Oncology Clinic
Ph: 07 5479 0000 | www.schoc.com.au
10 King Street, Buderim, 4556

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Federal Election,

Recently I attended the AMA National Conference, with Dr Wayne Herdy, whose comprehensive report is included in this newsletter.

Photos from the left:

1. Dr Ian Wilkey, RFD and his wife, Hannah Wilkey RFD at "Dinner for the Profession". A previous Medical Superintendant at RBWH

2. Dr Wayne Herdy, and Dr Chris Zapella and Dr Catherine Yelland (Dr Zelle Hodge has her back to camera)

3. Dr Herdy and his wife Monique at the "Dinner for the Profession"

4. AMA National Conference Meeting - new president, Dr Michael Gannon, and

5. Dr Geoff Hawson and his wife Kim at dinner for the profession.

6. The Missing member of the three Amigo's, Dr Michael Kennedy, "The missing Amigo - found"!

Many thanks Dr Herdy, for this report.

The Federal Election Campaign is heating up from both sides, with Medicare taking a very prominent position on both sides, with the Medicare rebate freeze, and lose of incentives to the pathology and radiology industry also a hot topic.

What is being seen at the moment is that the medicare rebate freeze has partly exacerbated the problem of öut of pocket costs, which in turn is resulting in patients delaying treatment and delaying visiting their GP because of costs. This is turn will have a roll on effect, putting more pressure on the public hospital system.

The issue of Medibank being taken to the Federal Court by the ACCC is also in the news, following patients accusing the private insurer of limits to pathology and radiology benefits when they were unexpectedly given out-of-pocket expenses while receiving treatment in hospital.

The ACCC is claiming that Medibank did not publicise the changes to its policy to its members for fear its reputation and business could suffer. One irate patient who was on "A Current Affair" recently stated that she had paid for her private health insurance for over 30 years, and never claimed. She then had a hospital admission for an operation, and found herself with over $8000 worth of out-of-pocket expenses, unexpectedly.

Well, this will affect Medibank's reputation, and its business will suffer, as patients need to know in advance what their costs are – many private patients do not have $8000 sitting in the bank to pay for such extra expenses.

The July 2nd election results will be very interesting, particularly in terms of what health policies we are faced with, which at present, from both political parties appears to be an evolving issue.

Sincerely

Kimberley Bondeson

AUSTRALIAN MEDICAL ASSOC PRESIDENT
DR CHRIS ZAPPALA

MEMBER'S UPDATES

Dear members,

AMA Queensland recently launched a series of videos underpinning the impact the Medicare rebate freeze will have on patients across Australia. The videos, which feature medical practitioners and members of the public, highlight the fallacies and deficient credibility of the rebate freeze policy and the long-term threat the freeze poses to high-quality medical practice.

When the rebate freeze was introduced by the ALP in 2013, a number of medical practices (and health funds) chose to absorb the resulting increase in costs. As the freeze stretches to seven years, however, this is becoming increasingly unsustainable and unjust. It is inevitable that the costs will trickle down to patients, disproportionally affecting vulnerable Australians.

As part of the Medicare freeze campaign, we've heard from practitioners in low-income areas, pensioners, retirees and families with small children – all concerned about how their care will be impacted moving forward.

Proponents of the freeze have disparagingly argued our advocacy work is financially-motivated – something which couldn't be farther from the truth. Rather, our goals are to protect Australia's health care system and ensure that every Australian has access to high-quality medical services, regardless of their financial status. If payment becomes a barrier to the equitability of our health care system, then it is impossible for that system to truly support those it serves.

Furthermore, it is absolutely understood that we do not want GPs (or any doctor for that matter) shackled to the enervating dictates of Government policy and bulk-billing – the rebate was never meant to be full payment for services, only a subsidy and we must begin the conversation to convince patients of this. Bear in mind, we will be arguing against a strong current of political expediency pushing us all towards conscripted bulk-billing through heightened, but unrealistic, patient expectations of free medical care forever and devalued general practice. The AMA needs to put in place a series of carefully crafted media messages to follow on from our current campaign that matures our message along these lines.

To appear greedy would diminish us greatly – so we must keep our message firmly rooted in empowering good clinical practice and, through this, achieving high quality care.

If you have not yet seen the campaign, I encourage you to visit the AMA Queensland website for more information. Please share the campaign on your social media networks and encourage your patients to make their voices heard.

The AMA recently welcomed a new leadership team and I am confident that under their stewardship we will make significant progress in the key areas affecting the profession and our patients. I have previously had the opportunity to work with Drs Michael Gannon and Anthony Bartone, who have taken over the roles of AMA President and Vice President, and I look forward to collaborating on key goals moving forward. The Federal AMA is also in the process of forming a new private doctors' sub-committee to ensure the voice of this sector is further enhanced through the Association.

Closer to home, many have discussed the decision not to allocate additional medical student places on the Sunshine Coast. Given the current training pipeline, this is ultimately for the best. While I'm pleased to see an increasing number of students interested in medicine, we must make sure that we have adequate high-quality training programs to accommodate young medicos. Currently we have nearly 17,000 medical students nationally and this number is increasing as first year cohorts become larger and Curtin University comes online. The conversation needs to switch not to a reduction in medical student places, but perhaps an expansion of key vocational post-graduate training opportunities that reflect robust workforce data and planning. Our colleges must be strong on this front and not lack resolve. Our association must keep providing a unifying, credible voice. Without it, we are nothing in the medicopolitical arena.

Sincerely,

Dr Chris Zappala,

AMA Queensland President

DR HERDY'S REPORT CONTINUED
FROM PAGE 5

dwelled on a comparison with airline pilots. Every pilot undergoes a palm-sweating intensive re-evaluation every six months, testing their technical competence and sufficiency of their knowledge. This comparison is limited. Medical practice requires testing also of non-technical competence especially in communication skills. Airlines pay for testing of pilots, but the speakers were emphatic that the person being tested must bear the cost of the process (but could not answer the question about how such a high cost could be built into the fees or rebates structure of private practitioners). For most health professionals, it is difficult to define what comprises poor behaviour, or to establish a reproducible objective test that has any meaning.

Patient review is regarded as unreliable. Patients have good awareness of waiting times and costs, and reasonable appreciation of communication styles, but very poor appreciation of complexity of consultations. Patient reports are also biased by unmet expectations, unrealistic as they might be (eg antibiotics for colds). There is a strong correlation between insight and performance, but there is no reliable test of insight. The well-known statistic was cited, that 3% of doctors generate 49% of complaints. A small number of individuals can be identified as high-risk. Self-review remains important. Feedback from patients is the most potent driver of self-review. Working in groups, where individuals are subject to constant peer review, is regarded as low-risk. Working in fringe or niche practices is regarded as high risk for complaints. It was suggested that if re-validation becomes reality, it might be targeted at high-risk individuals or clusters.

The question of older doctors inevitably rose. And inevitably a parallel was drawn with driving skills in the aged. An important principle raised was that any assessment that is age-related, if it is not to trigger anti-discrimination legislation, must be based on clear evidence. Again, even if there were any evidence extant, it is difficult to create a reproducible objective test. My sense is that the authorities are keen to introduce periodic re-accreditation. "They just DON'T know (yet) how to do it."

PRIVATE HEALTH INSURANCE.
We were lectured by Dr Michael Horvath from Ramsay Health and Dr Linda Swan from Medicare Private. Health insurance is global, and the same problems are emerging internationally. The major underlying challenge is affordability. The three major factors contributing to rising costs are (a) an ageing population, (b) increasing rates of chronic disease, independent of age, and (c) the development of new (or modified) technologies and medications.

A few statistics. 76% of health services in Australia are delivered in the private sector. 46% of Australians have health insurance but there is a trend towards the cheaper less-inclusive products. Some of the costs are in the community sector, eg the most expensive single pharmacological agent is a new anti-rheumatological. However, the strategies being adopted by the insurers focus on hospital practice, especially the private surgeons and special attention to re-admissions or prolonged admissions for complications of surgery. Casting a wider net, the insurers are also looking at patient-reported outcomes as a measure of quality and safety. Controversially, benchmark performance reporting and pay-for-performance are being considered, with acknowledgement that this will distort behaviour, disadvantage the most vulnerable, and potentially opens the door to managed care.

I asked my favourite question about waste being caused by inadequate handover between sectors (USA figures estimate that fragmentation of care increases health costs up to 30%). The response was disappointing: the insurers have no policy on efficient handover and considered that handover problems should be handled locally.

OTHER POLICY SESSIONS
The conference was also treated to policy sessions on (a) Assisted Dying – Exploring Members' Perspectives, (b) Closing the Gap, and (c) Bullying and Harassment – Changing Culture. Although these policy sessions covered a wide range of issues, and may have been cathartic for the participants, regrettably little new emerged from the discussions to justify a special report. None came to any conclusions, and as far as I could see, did not raise any new issues that have not already been aired repeatedly, also without any clear conclusion.

URGENCY MOTIONS.
There were two urgency motions. The first was lengthy and wordy, but called for a commission to be formed to investigate membership and recommend a plan for re-invigorating and sustaining the AMA. It did not pass the vote.

The second was directed at the manner in which the AFP has investigated doctors seeking justice for asylum-seekers. Although the motion was, to my lawyer's mind, not a competent one, it passed almost unanimously.

The motion is advisory to Federal Council and it remains to be seen what Council does in response to the motion.

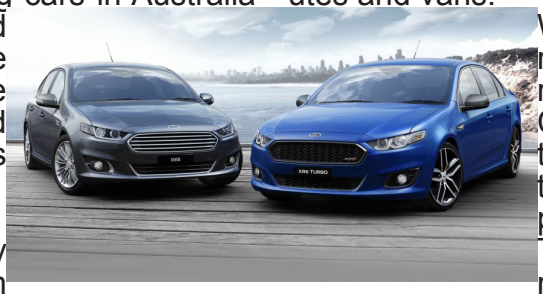
Your reporter is Wayne Herdy, AMAQ Councillor, attending as Queensland delegate.

MEDICAL MOTORING
WITH DOCTOR CLIVE FRASER

Safe motoring,
doctorclivefraser@hotmail.com.

"Ford Farewell"

In October 2016 Ford will cease manufacture of the Falcon and Territory in Australia forever. General Motors and Toyota will follow suit next year. Ford started assembling cars in Australia in 1925 with the Model T and then the Model A. Over the years there have been some great milestones with Ford Australia building the world's first utility in 1934.



After World War 2 assembly continued of models from Britain (Pilot, Prefect, Consul, Zephyr, Zodiac, Anglia, Escort and Cortina), all right-hand drive and meant for British roads. The Laser (Mazda's 323) was assembled by Ford in Australia from 1981 and the Telstar (Mazda's 626) from 1983.

But there was only ever one model made by Ford in Australia that we could call our own, the Falcon. First produced in 1960 there was a lot of North American DNA in this car to begin with. Even the Ford manufacturing plant at Broadmeadows in Melbourne had a roof that could disperse snow compliments of its Canadian design. Without import tariffs the locally made 1960 XK Falcon could finally compete with the Holden on price. The XK had more powerful engines (2.4 litre with 67kW and 2.8 litre with 75kW) versus the FB Holden (2.3 litre with 56kW). A 1960 XK Falcon manual cost $2,264 and Ford also offered a two-speed automatic option for an extra $248.

Early Falcon models weren't noted for their suspension durability as our outback roads weren't as smooth as the American highways they were designed for. But the evolution of Falcon models spawned memorable cars like the 1971 XY GTHO Phase 3 which at the time was the fastest 4 door production car in the world. By 1972 the XA Falcon was totally locally designed and the model line-up included a 2 door hardtop.

The XB hardtop was immortalized by the Mad Max movies and it now sits alongside the Batmobile in a Miami motor museum. Falcon sales peaked in 1995 with 81,366 sedans and wagons and 8,313 utes and vans.

Whilst Falcon and Holden sold roughly equally for years the release of Holden's popular VT Commodore in 1997 just before the unpopular AU Falcon saw the Falcon's market share plunge, and it never recovered. The final FG X Falcon was released in 2014.

After 3 million Falcon's had hit Australian roads the 2016 FG X is arguably the best looking of all. It's a shame that there are so few of them out there.

My nostalgic trip to the local Ford dealer was like visiting a ghost town and the salesman even apologized for the lack of activity. He did have a shiny new Mustang to show me, but there was no delivery of that model until 2017.

There was only one new Falcon FG X to view.

Ford's web-site prices a standard Falcon FG X sedan with the four litre non-turbo engine (195kW) and six speed automatic at $39,925 drive-away. The four cylinder two litre EcoBoost engine (176kW) is a $319 option. It's almost as powerful as its six cylinder brother, but it's much more economical, lighter and nicer to drive.

So why haven't punters been buying the Falcon FG X if it's so good. The end of the model line has savagely hit re-sale values.

A check of the RedBook shows that a 12 month old 2015 four litre FG X will trade for $14,500 to $16,700 and sell privately for $18,400 to $20,600.

That's some serious depreciation of at least 50% in only one year. As it's such a nice car I reckon it's still a bargain (in the second-hand market).

Safe motoring, Doctor Clive Fraser

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RELIGION, GOD AND THE EGO by Dr Mal Mohanlal

Be aware of the Ego, the greatest confidence trickster and survivor in the mind. This is a self-centred world we have created where the ego or self is always involved in whatever we do. If you give an inch, it will want to take a foot. You may be perfectly happy in whatever you are doing but some smart Alex will always come up with a different plan to upset your apple cart. Yes this ego is an entity in the mind that considers death as an anathema and will do anything to survive forever and ever. Yet this entity is trapped in the Time dimension of its own creation; because when one travels in time one does not realise that, there is always a beginning and there is always an end.

Since death is considered the end, and reflects the limitation put by Time and since the ego does not want to come to an end, it projects the concept of survival after death. That is we develop this idea that we will all somehow continue to survive after death. Thus we have created the theories of reincarnation and resurrection to enable the ego to find comfort in the belief that we will all continue to survive after death. In the reincarnation theory we are born again in a different body and in the resurrection theory we are brought back to life again in the same body.

As one can see that this universe is an awe-inspiring and timeless place. It is subject to certain physical laws which science has helped us discover. The living and the non-living are all under the influence of these laws. There is no exception to this rule. The universe reflects intelligence at work that makes our mind boggle. When we experience these forces of nature, we are humbled by its might and power where emotions and sentiments have no place at all. With our puny minds and the fears we possess we are compelled into believing in the existence of a Superior Intelligence. Hence begins our belief in God, Allah or Bhagwan etc. But surely this God or Superior Intelligence cannot be something personal. As one can see that when a natural disaster strikes, like a tsunami or an earthquake, if you find yourself in the wrong place and at the wrong time, whether you are a Hindu, Christian, Muslim or a Buddhist, it does not matter, you will be gone.

So how did we acquire a belief in a personal God, Allah, or Bhagwan etc which most religions have as the basis for their existence? People from all over the world have some belief in a personal God which has been derived from times immemorial. Even today primitive tribes have such beliefs. All major religions preach oneness of mankind yet the individual who holds that belief would say that his was the only one true religion and the others were all false. One will preach Allah is God and there is only one God; others will say that different religions of the world are only different paths to the same one God.

The only problem with all these beliefs is that it is dividing mankind. The world is in chaos because of our beliefs. Admittedly a belief can unite a group of people under one faith. But what happens to people who do not belong or have never heard of that belief? Surely it is a divisive process and should we be killing each other over our beliefs? Is it rational to hold such beliefs? This raises a fundamental question. Is it possible for the ego or self to exist without a belief? The answer to this question lies in our perception of reality. The simple answer is yes. All you have to do is ask yourself, do you have to believe in the sun to enjoy the benefits from the sun? Clearly the answer is no.

So how have these belief systems become so important in our lives? If one observes carefully one will find that beliefs are used to strengthen the ego. We hide behind our beliefs. Beliefs make us feel comfortable because we do not have to think for ourselves. Beliefs give us our identity, our culture. What the ego fears most is losing its identity and culture. Hence if anyone attacks our beliefs we are forced to defend and fight. Is it not time we questioned our beliefs? In my mind there is no doubt about an existence of a Superior Intelligence or a Universal Mind but it would be very naive indeed to give it personal characteristics and arrive at the concept of a personal God.

So how did we arrive at the concept of a personal God? When we are born, we need the protection of our parents to grow up. We are conditioned to think in terms of the Father as the provider and the Mother as the nurturer in the family. Hence we always look to the father for protection and guidance. Such conditioning leads us to create a personalised image of this Superior Intelligence or Universal Mind which according to various religious beliefs becomes known as God, Allah, or Bhagwan etc. By making this Superior Intelligence or Universal Mind a Father figure we now have a heavenly Father who will provide, protect and guide us. Now we as children can bow in reverence and behave whichever way we want since this Father will always forgive, protect and guide us. Is it not a very comforting thought that by worshipping this deity of our own creation, we will all somehow be protected and survive death?

Clearly one can see that most people find the belief system they use help them organise and bring comfort and meaning to their lives. But is it not a disorder of perception if a believer is willing to die and kill a fellow human who may not belong to that belief system? In my mind to have a belief in a personal or an impersonal God, or to be a believer or a non-believer, really does not matter, because when the sun shines it shines for all of us. However since we are all trapped in time, and since we are all seeking immortality, we should be looking at our own mind for the answer and find out how we create time.

The Timeless dimension is all round us yet most of us are not even aware of it or recognise it. We get the glimpses of the Timeless dimension when the observer in the mind and what is being observed become one phenomenon. When you next go on to the mountain top or go into the bush please become aware and experience this Timeless dimension I am talking about. You can even do this while walking in the garden. You will find yourself being a part of the Universal Mind and the Universe You do not have to believe what I say. Use your power of perception, insight and awareness to find out for yourself what I am talking about.

Anonymous wrote: “You were born original, don’t die a copy”. I am afraid most of us do. Read my book “The Enchanted Time Traveller A Book of Self Knowledge and the Subconscious Mind” and discover the Timeless while you are alive, not after you die. Visit Website: http://theenchantedtimetraveller.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 Montserrat Cancer Care 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.** Patients from our North Lakes Clinic can attend our Sunshine Coast Clinic at no additional charge for this service.

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.

Dr Kieron Bigby and Dr Darshit Thaker can be contacted via our North Lakes Clinic By calling (07) 3833 6755.

Kind Regards

Montserrat Cancer Care Team

**The Orbis Cooling machine*

Aged Care Funding Strategies

The biggest concern for many people moving into residential care is how they pay the Refundable Accommodation Deposit (RAD) quoted for a room. This ranges from around $100,000 to $2 million but it is common to see RADs of $350,000 - $600,000.

Let's examine three important facts that you need to know about RADs.

Fact 1 – This is not lost money

The first thing to know about a RAD is that the total amount is fully refundable when they leave care (if paid since 1 July 2014), unless they allow the service provider to deduct other fees to help with their cashflow.

Repayment is also guaranteed by the Federal Government if paid to an approved provider – an important thing to check when they are selecting a care provider.

Fact 2 – The family member doesn't have to pay the lump sum

Accommodation payments are quoted as a lump sum but are also converted to an equivalent Daily Accommodation Payment (DAP).

The interest rate used for this conversion is currently 6.28%. For example, a RAD of $400,000 converts to a DAP of $68.82 per day.

If a person accepts a place in a residential service, they can choose whether to pay the full RAD, the full DAP or any combination of the two. The important point for the family is that they don't need to make this choice until 28 days after moving into care and the service is not permitted to pressure them to choose any particular option.

Fact 3 – Even if they have less assets than the published RAD it may be affordable

If an individual doesn't have enough assets to pay the RAD the first step may be to see if they qualify for government concessions as a low-means resident. This would require their share of assessable assets to be less than $159,423 (up to 30 June 2016).

If they don't qualify, they will need to find a way to fund the full accommodation payment requested by the service. If they don't have enough assets, paying a part RAD and part DAP may help, but only if they have surplus cashflow to pay the DAP.

One further strategy option which might be appropriate is to pay as much of the RAD as an individual can afford and instruct the service provider to take the DAP each month (on the unpaid amount) out of the RAD they have paid.

This option leaves their income to meet daily care fees and living expenses but reduces the RAD refunded when the individual leaves.

Example: 	Bert is moving into residential care. He is a widower on the full age pension with a home worth $420,000 and $20,000 in the bank. The service he and his family have chosen is asking for a RAD of $530,000 (or $91.19 per day). Bert is worried that he cannot afford a place in this service without asking his children for help. He sought advice on his options and decided to: • Sell his home • Use the net sale proceeds to pay a $400,000 RAD, leaving a DAP of $22.37 per day on the remaining $130,000 • Instruct the service provider to deduct the DAP each month from his RAD This leaves the $22,721 age pension he receives to cover his daily care fees of $20,572 per year plus some personal expenses. Bert is financially self-sufficient and keeps a $20,000 cash reserve to meet other expenses. Note: Rates current to 30 June 2016

Always seek advice so that your full financial and family circumstances can be taken into account to determine an appropriate funding strategy.

If you have any questions please give Kirk Jarrott a call on 07 54379900.

Great Train Journeys

The Canadian Rockies

By Cheryl Ryan

The best way to experience the expanse of enchanting Canada is on the sleek, silver '50s railway coaches that provide for a relaxing journey with stunning views, warm service, good food, and the comfort of delightful conversations with our co-passengers. The great Canadian train odyssey is all about the beauty of the prairies, the mighty Niagara Falls, the soaring Rockies including, Jasper and Banff, Butchart Gardens, Hell's Gate, Victoria and Vancouver.

The Perfect Train Escape

1. The Union Station, Toronto: This is where we embark on our magical odyssey through Canada's treasure-troves. Built in the early 20th century in the luxurious Beau Arts-style, this station and its imposing hallway is an architectural wonder.

2. The Canadian Shield: Dense boreal forests separated by multitudes of clear water rivers, lakes and bare rocks offer unequalled postcard-perfect scenery. Home to the largest game reserve in the world, you may catch a glimpse of bears, moose, deer, and mountain goats as the train whistles by.

3. Jasper: The largest National Park of the Canadian Rockies, Jasper National Park, a UNESCO World Heritage Site features acres of scenic mountain wilderness. Famous for a great backcountry trail network, and the Columbia Icefields, Jasper is home to the rarest of wildlife including, moose, wolves, caribou and grizzly bears. The enchanting Pyramid Lake and Spirit Island are other must-see sites.

4. Banff National Park: It is undeniably one of the most breath-taking places on Earth. Popular for the emerald waters of Lake Louise, glistening glaciers and waterfalls, the Sunshine Meadows, and the Icefields Parkway, the Banff National Park are some of the go-to places for awe-inspiring sightseeing and tremendous recreational activities.

5. Waterton Lakes National Park: One of Canada's famous mountain parks, Waterton Lakes National Park is where you can be one with nature amidst beautiful alpine meadows, prairies of wheat and

grass, soaring mountain peaks, and an assortment of flora and fauna.

6. Golden, British Columbia: Nestled between the Purcell Mountains and the Canadian Rockies, Golden is a low-key place blessed with abundant beauty. Apart from sightseeing, it offers access to some world-class restaurants, as well as tons of adventurous activities like hiking, snowmobiling, golfing, skiing, snowboarding, and by the end of the day, soul-revitalising relaxation.

What have we planned for you?

A comprehensive itinerary has been planned to let you make the most of the charm and grandeur of the Canadian Rockies and everything it has to offerTrip to the Niagara Falls, with an opportunity to see both the American and Canadian sides of the falls on the "Maid of the Mist" boat cruise

1. A guided Trans-Canada Rail Journey from Toronto, past the gorgeous sceneries, enthralling Rockies, majestic waterfalls, serene lakes, and much more

2. Don't miss out on the spectacular view of zillions of beautiful flowers and waterfalls at the Butchart Gardens.

3. Tour of Jasper, Pyramid Lake, Jasper Gondola, and optional cruise on the Maligne Lake

4. Guided white water rafting trips in the Jasper National Park and the Canadian Rockies

5. Guided mountaineering and rock climbing trips to the Rockies assisted by professionals

www.123Travelconferences.com.au

Chiropractors and GP Referrals – There Is A Solution!

Dr Geoff Harding, Sandgate Spinal Medicine Clinic

There has been lots of discussion recently regarding GP referrals to chiropractors. The RAC GP has called on GPs to stop referring to Chiros especially for managements of children and adolescents and more especially when the referral relates to the treatment of conditions such as asthma, reflux and developmental abnormalities.It seems that there are those GPs who would never refer to a chiropractor for any condition, those who would refer adults for treatment of musculoskeletal pain problems, and some who would refer for all manner of conditions which the Cairo is claim they can treat.

I would like to point out that there is a discipline called Musculoskeletal Medicine which deals with the nonsurgical treatment of common musculoskeletal pain conditions. Whilst there are medical practitioners (like myself) who practice solely in this area, there are many GPs amongst you who have completed some training in the medical treatment of musculoskeletal pain. This is (or should be) part of General Practice – that is, the ability to assess and treat those common nonsurgical conditions which present here in general practice. Prof John Murtagh who would be known to most of you as Australia's most influential GP firmly believes that GPs should be able to treat many of these conditions in the acute stage so as to avoid the development of chronic pain problems. John's first published text was "Back Pain And Spinal Manipulation", and in it there are numerous illustrations of him (and Dr Clive Kenna) performing high velocity thrust manipulations to the cervical, thoracic, and lumbar spines. The text that they wrote back in the mid-1980s was a synthesis of manual medicine techniques taught in Europe to medical practitioners including neurologists, rheumatologists, and even orthopaedic surgeons.

Many GPs would have attended John's weekend courses or workshops which were part of conferences where he would have demonstrated the examination and treatment techniques. I, and three other medical colleagues were asked by John to run these courses in Queensland and I continue to run workshops for the rural doctors, on a regular basis. In the last 25 years approximately 1000 doctors have attended these courses in Queensland alone. That means that there are a lot of you out there (or at least colleagues of yours) who could treat many conditions which would otherwise, perhaps, be referred to the chiropractors.

How I should point out that there are divisions within the chiropractors themselves between those who simply feel they should be treating musculoskeletal pain problems and those who claim that they should be treating the medical conditions like asthma et cetera. There is no evidence to back up the latter claims and in the interests of your patients I would suggest referral (especially for children) to the chiropractors is contraindicated.

Over the years I've seen the decline in numbers of GPs who perform intra-articular injections for common problems affecting the shoulders, knees, ankles, first MCP joints, and many other joints in the body. Initially the decrease came when the government stopped the rebate for these injections and the result has been a deskilling of General Practice with respect to injection therapy. In many instances these injections are extremely useful for the treatment of e.g. rotator cuff tendinopathy, and osteoarthritis of many joints where surgery is not indicated or not desired. The evidence for efficacy of an ultrasound-guided injection versus that of a well practised blind technique is not that good. In many cases a well-directed "blind" injection is just as efficacious, likely to be more timely, and certainly less expensive than performing ultrasound-guided injections. One of the comments often made to me by younger GPs is that they are afraid to undertake these procedures because they're worried about the medico legal repercussions that might visit them. I should tell you that in the UK certain physiotherapists have done training in intra-articular injections and are accredited to do so in the NHS. Currently in New Zealand there is an active push from the physiotherapists to the New Zealand government for them to be performing intra-articular injections. And you will be no doubt surprised that there are informal approaches currently being made to the Australian government by the physiotherapist's association for Australian physiotherapists to be allowed to do the same. The basis of their argument is that "we can save you money by doing these injections in primary care because not many GPs are doing these injections". In other words in spite of some earlier criticisms from physios and Chiros that these injections were either dangerous or ineffective, the push now is for them to be given a guernsey to perform them.

So next time you have a patient who has back pain, neck pain or headaches, shoulder pain etc, follow your normal practice and rule out the red flags, and then consider either re-learning some of the skills taught you by John Murtagh or others, or look around in your practice for someone who has these skills, and consider referring your patient to them in the first instance. In many cases you will find this is very acceptable to your patient, in their best interests, saves time waiting for treatment, and will give you a new confidence in treating musculoskeletal pain.By the way, there are very, very few conditions where children need to be treated with manual therapy and there is no evidence that manual therapy will cure asthma, epilepsy, reflux, or developmental abnormalities.

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QUEENSLAND JOINS NATIONAL DOCTOR HEALTH NETWORK

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Queensland has joined the new $2m national network of doctors' health services, paving the way for Queensland doctors and medical students to access advisory, referral and advocacy services.

New funding arrangements have now been finalised between Doctors' Health Services Pty Ltd (DrHS) and Queensland Doctors' Health Program Pty Ltd (QDHP).

The AMA and the Medical Board of Australia welcomed the milestone, which brings Queensland into the national network with New South Wales, South Australia, the Australian Capital Territory and the Northern Territory.

AMA President, Dr Michael Gannon, welcomed the funding arrangement as another important step toward ensuring that all doctors and medical students have access to high quality health care, no matter where they live and work.

"I know how important the work done by doctors' health advisory services in my home State of Western Australia is, and it is great to see that soon doctors and medical students across the country will have a health service they can call on," Dr Gannon said.

The Medical Board of Australia is funding DrHS, a wholly-owned subsidiary of the AMA, to coordinate the delivery of doctors' health services for doctors and medical students in all states and territories.

Medical Board Chair, Dr Joanna Flynn, welcomed the expansion of services to doctors and medical students in Queensland.

"The significant boost to funding for services in Queensland is good news for the roll-out of new arrangements for doctors' health services nationwide," Dr Flynn said. "The Board is pleased that the funding will increase the level of support being given to the profession in Queensland."

DrHS Chair, Dr Janette Randall, said that for many years the Doctors' Health Advisory Service Queensland had been providing a point of contact for doctors and medical students, as well as working on programs to promote doctor health.

Dr Randall said DHASQ's new subsidiary organisation would be much better resourced and was now able to appoint a medical director to organise an expanded range of services to Queensland doctors and medical students.

DrHS is working to finalise arrangements for services in Victoria, Tasmania and Western Australia, which will complete the national network of services.

20 June 2016
CONTACT:

Kirsty Waterford
02 6270 5464 / 0427 209 753

John Flannery
02 6270 5477 / 0419 494 761

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Dear Doctors

The Redcliffe and District Medical Association Inc. have had another successful year of interesting and educative meetings on a wide variety of medical topics. Show your support for your Local Medical Association to continue the only local convocation for general practitioners and specialists to socialise and to discuss local and national medico-political issues.

This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and speakers are most welcome. Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost.

RDMA SUBSCRIPTION FORM - INTERNET PAYMENT PREFERRED

Treasurer Dr Peter Stephenson Email; GJS2@Narangba-Medical.com.au

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i) Complete Form and Return: C/- QML or RDMA at PO Box 23 Redcliffe 4020

2) Or Emailing to GJS2@Narangba-Medical.com.au

General Practitioners Liaison Officer Updates #1

Dr James Collins– June 2016 james.collins2@health.qld.gov.au

WHAT'S NEW AT REDCLIFFE HOSPITAL?

I would like to introduce myself as the new GP Liason Officer at Redcliffe Hospital and it is my pleasure to provide you with the first GPLO update. Redcliffe Hospital and I are involved in a range of initiatives listed below to improve communication and collaboration between the hospital and GPs and to deliver better outcomes for our patients.

1. Alternatives options to the Emergency Department for patients
With the increase in winter presentations at public hospitals I thought it would be useful to be aware of alternatives to the emergency department for your patients including direct access to the Redcliffe Hospital medical team, hospital in the home, residential care liaison service etc. A fax has been sent to your practice to inform of these. If you haven't received this fax please email me your details and where I can forward these details to you.

2. GP education event – August 2016
I am planning the first GP education event with the orthopaedic department from Redcliffe Hospital. It is to be held at North Lakes Health Centre. This will be your opportunity to network with the public specialists from Redcliffe Hospital and your GP colleagues. You will also be able to ask questions to the director of the service, learn about new services and developments. More information will be coming soon to your practice or email me if you have any questions.

3. Discharge Summaries
Redcliffe Hospital continues to work to improve discharge summaries and outpatient letters and we will hope you see this improvement over the coming months.

4. Named outpatient referral letters
Sending an outpatient referral to a named Redcliffe hospital specialist (referring to for example "Dear Dr Denise MacGregor Clinic" rather than to "Dear doctor, or public clinic" in surgical outpatients) helps improve funding for services at your local hospital.

The names of Redcliffe Hospital specialists can be found on the e-referral outpatient templates in Best Practice or Medical Director. They are also easily found on the Central Patient Intake (CPI) website: www.health.qld.gov.au/metronorth/refer/ if you don't use the e-referral templates.

Your patient will still be seen at the next available outpatient clinic but may be seen by another doctor if there is a longer wait for the requested named specialist or there is a more appropriate doctor for their condition.

5. Essential information required for an outpatient referral
The new Hospital Central Patient Intake (CPI) web site has been launched. These contain the outpatient referral guidelines with the minimum clinical information required to send a referral to each speciality. These pages also have useful information about each outpatient department and I encourage you to view these They can be found at: www.health.qld.gov.au/metronorth/refer/

6. Review of GP referrals to outpatient departments
The GP Liaison Officer team at Metro North Hospital and Health Service is currently reviewing outpatient referrals from GPs. It is looking at the quality of referrals and provide options for new models of care.

The review will include ensuring the appropriate clinical information is provided in all referrals so the urgency of a referral can be safely prioritized. Referrals with insufficient information may be increasingly sent back to the GP in the future for updating. I encourage you to review the CPI web page (listed above) to ensure you are aware of essential information required.

As demand for outpatient appointments rapidly grows, good quality referrals makes sure the best pathway of treatment for patients can be identified.

7. GPs working together with the hospital service
Do you have a special interest in a specialist area such as back pain, etc? If so please let me know what your specialist interest is so I can get in touch as we plan future opportunities with hospital service.

Are you interested in shadowing in an outpatient department to gain extra knowledge in certain specialist areas? Some specialists such as neurosurgery are keen to meet with GPs who may want to attend clinics to improve their specialist knowledge. If you are interested please contact me at james.collins2@health.qld.gov.au

Looking forward to hearing from you and keeping you informed in future newsletters.
James