RDMA
RDMA & NLMA's Joint Newsletter
NEW Meeting Date 28th May
Newsletter
MAY 2015

Gallipoli The Story of AE2

See Where We Work & Live on page 20

Submarines in the Dardanelles, 1915. The Story of AE2 the Australian submarine, the first Allied warship to make it though the Narrows, was the AE2 commanded by Irishman Lieutenant-Commander Henry Stoker. Lieutenant Commander Stoker and HMAS Submarine AE2 Got up through the Narrows. Continued page12 and 20

Lieutenant Henry Stoker taking a bath on the Royal Australian Navy submarine AE2, c.1914. [Photograph in Henry Stoker, raws in the Wind, London, 1925]

President's Report Dr Kimberley Bondeson

Anzac Day has come and gone - paying our respects on its 100 year Anniversary.

It was with pride that I placed the wreath to respect and honour our servicemen from Australia and New Zealand, on the 100th anniversary of the Gallipoli Landing, on behalf of the Redcliffe and District Local Medical Association.

On dawn the 25th April, 1915, 100 years ago, the Australian Anzac's landed on the Gallipoli Peninsular in Turkey at what we now know as Anzac Cove. Australian causalities for the Gallipoli Campaign amounted to 26,111 comprising of 1007 officer and 25104 other ranks.

Gallipoli became the common tie forged in adversity that bound the colonies and people of Australia into a nation.

Dr Kimberley Bondeson
B.Sc(Hons). MBBS, FRACGP, DAME.

President
Redcliffe and District Local Medical Association.

RDMA & NLMA's Joint Newsletter

WELCOME FROM

Dr 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 2015 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

	Tuesday	February 24th
	Wednesday	March 25th
	Tuesday	April 28th
Next	Thursday	May 28th Change of Date
	Tuesday	June 30th
	Tuesday	July 28th
	Wednesday	August 26th AGM:
	Tuesday	September 15th
	Wednesday	October 28th
	NETWORKING:	
	Friday	December 4th

RDMA NEWSLETTER DEADLINE

Advertising & Contribution is 15th JUNE 2015
Email RDMAnews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

NLMA 2015 Bi-MEETING DATES:

For all Northside LMA Meeting & Membership queries contact:
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Website and Link:
Northside Local Medical Association Website
Link: http://northsidelocalmedical.wordpress.com/

Meeting Times: 6.45 pm for 7.15 pm

1	10th February 2015	2	14th April 2015
3	9th June 2015	4	11th August 2015
5	13th October 2015	6	8th December 2015

INSIDE THIS ISSUE:

CLASSIFIEDS remain FREE for current members. To place a classified please email: RDMAnews@gmail.com with the details. Classifieds will be published for a maximum of three placements. Classifieds are not to be used as advertisements.

AUSTRALIAN MEDICAL ASSOC PRESIDENT
Dr Shaun Rudd

MEMBERS' UPDATE

I'm delighted to report on the successful launch of Part 1 of AMA Queensland's Health Vision last month focusing on public health. In particular, our calls for addressing obesity received the attention of members, media and the general public alike.

Following the launch, AMA Queensland has worked with a number of organisations that share the same goal of a healthier Queensland. I was delighted to attend and speak at a recent parliamentary breakfast to jointly promote the Move More, Sit Less campaign with the Heart Foundation. The campaign encourages a more active lifestyle and offers practical tips and swaps to move more. It's a simple message but one that will hopefully resonate with communities in Queensland and across Australia.

I also recently had the pleasure of opening the Global Weight Management Congress and discussing the Health Vision as well as AMA Queensland's Lighten Your Load Campaign. Attended by doctors, dieticians, psychiatrists and other health professionals, the conference was a unique opportunity to focus on the importance of a multifaceted approach to successful and healthy weight loss. Knowing the work and consultation that has gone into the Health Vision, I am glad to see it facilitating such an important discussion on public health and look forward to the launch of Part 2 of the Health Vision, focusing on workforce and training, at next month's Junior Doctor Conference

Regardless of what other measures are implemented, the health system in Queensland cannot function without a highly trained workforce. We need robust workforce modelling and planning to ensure we have adequately funded undergraduate, prevocational and vocational training places.

Of particular concern, is ensuring the shortage of qualified medical practitioners in rural areas is being addressed. continued P5

AMAQ President cont from P4
Dr Shaun Rudd

Rural practitioners are the backbone of healthcare in these areas, so focus needs to be on training and support in addition to increasing the number of rural doctors. At our inaugural Junior Doctor Conference last year, we hosted a forum that allowed medical students and doctors in training to discuss some of their key concerns. The most recurring of these were worries and concerns about intern placements and "the training pipeline." Part 2 of our Health Vision will focus on a number of workforce and training issues affecting young doctors, and we are happy to be able to launch it alongside this year's conference.

In addition to our work on the Health Vision, we continue to monitor efforts to extend the scope of practice for allied health professionals in the public health system. We continue to seek clarification on recent radiographer commenting/reporting and work with the Colleges to continue providing a safe and high quality service to patients.

Sincerely,
Dr Shaun Rudd,
AMA Queensland President

LETTER TO THE EDITOR

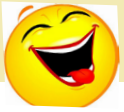
Vaccination Article by Dr Wayne Herdy April Ed
Response from Noeline Ferguson

Wayne, this is an excellent article and I agree with everything you wrote. I have always believed in vaccination, sadly though there was not much available when I was a child, but my three and the grandies got everything that was available. I will always remember nearly losing Tori because of parents at day care not vaccinating. She was about two, fully vaxxed, a chronic asthmatic and caught whooping cough from an unvaxxed child.

If they could have seen this tiny little girl coughing and not being able to breathe they may have realised the importance of it. She was in hospital for days. But why I am I describing this to you, who has seen far worse. I remember too the terrible callipers polio sufferers had to wear, usually for the whole of their lives, and the horror of the Iron Lung. Another dreadful disease that the younger parents would not have seen, nor even known about.

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

Interesting Tidbits **NATTY MOMENTS:**



Great Wife & Husband Laughs

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

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

All the women raised their hands.

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

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

The women were then told to take out their cell phones and text their husband:

- I love you, sweetheart.

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

Here are some of the acceptable replies:

1. Who the hell is this?
2. Eh, mother of my children, are you sick or what?
3. Yeah, and I love you too. What's up with you??
4. What now? Did you crash the car again?
5. I don't understand what you mean?
6. What did you do now?
7. ?!?
8. Don't beat about the bush , just tell me how much you need?
9. Am I dreaming?
10. You had better tell me who this message is actually for, and how long this has been going on....
11. I thought we agreed you wouldn't drink during the day.
12. Your mother is coming to stay with us, isn't she?*

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

2015 Budget & Revised Medicine Australia's Code of Conduct.

BUDGET 2015.

After a tornado of controversy and concern that followed in the wake of the 2014 Federal Budget, this year's effort has been a mere zephyr.

There are really only two items of importance to doctors.

To start with, I discount the apparently massive reduction in direct Federal funding to hospitals as relatively unimportant. Unimportant because it is balanced by a redistribution of GST money, so hands over control to the Sates on how they spend the money. The trade-off is between direct Federal money to hospitals or indirect money to the States to spend as they choose, hospitals or otherwise. Shift the blame to the States if hospital budgets are cut.

The big one for me is still the freeze on Medicare rebates. It doesn't make any difference to our gross or net incomes today or this month. But it is a programmed and very substantial erosion of government support to our fees over the next five years. My words are chosen – it does not determine our fees, but for those of us who practice in areas of social disadvantage it will strongly influence our fees. This will make large inroads into our gross incomes over the five years. But because our costs are not fixed but will continue to rise, it will make dramatic inroads into our net take-home pocket money. All private practitioners will have to look closely at their billing practices, and I think that almost all of us will have to tighten up our charitable and altruistic philosophies as this change starts to bite.

The second big ticket item is the incentive to small business (and most of us are still small businesses under $2M) to go out and spend on capital purchases. We can claim a full deduction on capital items up to $20K instead of having to claim amortized costs over several years. I don't think too many doctors are going to rush out buying new cars (unless Clive Fraser can tell us how to pick up a new Benz under $20K), but I see a rush to update computers and vaccine fridges and sterilizers. I am happy that this is an incentive to consumer confidence, and I am happy that many or most of my colleagues will get some new toys a year or two earlier than they might otherwise have chosen. But the reason why I see this as a big ticket item for the medical profession is more than a matter of money – it is an incentive for us to go and upgrade our practices. This is an incentive to improve the standards of service delivery to our patients. And at the end of the day, I am all about quality and safety of service delivery to patients. I don't know if Joe Hockey gave a moment's thought to the opportunity that he gave for us to make ourselves better, but that is the opportunity that he has put into our hands. Let's make the most of it.

REVISED MEDICINE AUSTRALIA'S CODE OF CONDUCT.

A very recent addition to the AMA Federal website reads as follows:

"Last month the ACCC authorised a new version of Medicine Australia's Code of Conduct. While the Code of Conduct governs the activities of pharmaceutical companies, there are important implications for medical practitioners.

Medicine Australia's new code requires its member pharmaceutical companies to report on payments or benefits provided to individual health practitioners that fall in the following categories:

- fees and/or speaking fees to a healthcare professional
- sponsorship for a healthcare professional to attend an educational event: airfares, accommodation and/or registration fees
- fees paid to healthcare professional consultants in Australia, or to their employers on their behalf, for specific services rendered by them: consulting fees, accommodation and airfares
- fees paid to healthcare professionals in their role as Advisory Board members: sitting fees, accommodation and airfares
- fees paid to healthcare professionals for the purpose of market research where the identity of the healthcare professional is known to the company
- payment of an educational grant or sponsorship to a specifichealthcare professional.

continued P7

AMAQ BRANCH COUNCILLOR REPORT continued from P6
Dr WAYNE HERDY

These requirements will be implemented in two stages. From 1 October 2015, pharmaceutical companies will collect data on these categories of payments so that they can publicly report on the payments made to individual health practitioners. In line with Australian privacy legislation, companies will need to seek consent from individuals before this can be published. Individuals will be able to withhold consent. However, from 1 October 2016, pharmaceutical companies will only be able to enter into relationships with practitioners who consent to this information being published. Individual information will be retained and published for three years."

This really only rationalises what we should have been doing all along. If a pharmaceutical company pays you a substantial amount of money or benefits, the public is entitled to know that you might have a bias. This is fair to the public, and the proposal is fair to the big pharma and to the profession.

The public does not want to know if you picked up a few sandwiches for devoting your private time in your lunch break to listening to a one-sided version of the latest drug starting with a Z. We are not talking about a few pens and oddments of crockery; we are talking about flash dinners at the Opera House. The public (and the profession) DOES want to know if you and your spouse enjoyed a holiday in a quiet resort in return for prescribing or recommending the latest zillion-dollar product that has marginal benefits over the existing plethora of competitors. The profession needs to hear opinion-leaders at the sharp end of medicine, but we also need to know their biases before we hear them. Maybe this will bring more common sense to the public disclosure table.

As always, the opinions expressed herein remain those of your correspondent,

Wayne Herdy,
AMAQ representative, North Coast district.

Introducing...

Dr Anil Sharma

FRANZCO

General Ophthalmic Surgeon

Announcing the opening of the

Central Lakes Eye Clinic

Dr Anil Sharma graduated from Medical School in 1988, completed his Post-Graduate training in Ophthalmology in 1994 and advanced eye training at Sydney Eye Hospital in 2000 and the Royal Adelaide Hospital in 2001.

He is a Senior Lecturer in Ophthalmology with the University of Queensland (UQ) and is actively involved with Qld RANZCO, AMA Qld and in the teaching program of medical students and supervision of Registrar at Royal Brisbane Hospital.

Central Lakes Eye Clinic which opened in April 2015 is a comprehensive specialist medical practice equipped with state of the art equipment and technology including:

- Total Care paperless EMR
- IOL Master Series 700 with Calisto
- Atlas 9000 Corneal Topographer
- Visuref Autorefractometer
- Cirrus 5000 HD – OCT
- Visucam 500 + Macula Pigment Densitometer
- Visual Fields HFA 860
- Forum Software Package

This enables full consultant assessment of all major diseases and disorders of the eye in a brand new, modern, purpose built medical practice.

Dr Sharma will be admitting patients requiring surgery into the new Day Procedure Unit at Caboolture Private Hospital where they will have access to the new, top of the range Alcon Centurion Phaco Machine and Zeiss Callisto Eye-Lumera 700 microscope.

Dr Sharma and Caboolture Private Hospital have both collaborated to make a significant investment for Caboolture and surrounding communities to provide this convenient, comprehensive assessment and treatment service on the same location where parking is at no cost.

The clinic will provide a much needed service to the local community and surrounding areas allowing patients to receive their assessment and treatment closer to home.

The procedures that patients may have undertaken include:

- Cat & IOL surgery
- Pterygium removal
- Eyelid procedures (Ectropion & Entropion) BCC excision
- Intra-ocular injections (intravitreal injections for macular degeneration), diabetes and other medical retinal disorders
- Vitreo- Retinal procedures (in the near future).
- Glaucoma surgery and laser procedures
- YAG, S.L.T. and retinal lasers

Contact Details

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Fax: (07) 3319 6507
www.cabooltureprivate.com.au
email: reception@centrallakeseyeclinic.com.au

Central Lakes EYE CLINIC

CABOOLTURE PRIVATE HOSPITAL

AMAQ BRANCH COUNCILLOR REPORT
GREATER BRISBANE AREA
Dr KIMBERLEY BONDESON

Medicare Rebate Freeze, GP Helpline, PCEHR & WA's New Medical School

Many thanks to all of you who have supported me and are allowing me to continue on the AMAQ Council for another 2 years and welcome to new Council Members who have also been elected for the Greater Brisbane Area.

One of the big issues facing all Doctors, both General Practitioners and Specialists, private and public, is the current freeze on the Medicare rebate indexation, which has been introduced with no end date.

Not only will this affect private GP's and specialists, but hospital specialists who access Medicare rebates will also be adversely affected. There are various reports in the media that this is "co-payments by stealth". By freezing the Medicare rebate, which does not cover operating costs, nor kept up with the basic CPI index since it was introduced, private doctors will be forced to slowly abandon bulk billing. It will also force hospital doctors to abandon bulk billing as well, unless the government subsides the bulk billing clinics at the public hospitals.

I am already aware, of some instances, in the public sector, where bulk billing clinics are not financially viable. This is certainly the case in the infamous GP Super Clinics, which when initially proposed, were to be 100% bulk billing and open 24 hours. Well, we know what has happened there. Locally, we have a new, magnificent building on the Redcliffe Hospital Grounds which cost $23 million dollars to build, and was left vacant for over 2 years.

The AMA is opposing this Medicare Rebate Freeze, at both a federal level and local level.

To me, it is quite simple. You cannot expect to continue bulk billing patients, if the amount of the Medicare+ rebate is frozen, but the cost of living, inflation, increase in wages, rent, etc continues to rise without being constrained. What happens? Practices start running at a loss, and many practices will be forced to close their doors. Doctors will look elsewhere to make a living, or will be forced to look at a new business model - one that does not include bulk billing. This will result in a large influx of patients going into the public system. We all know that the cost of the public system treating a simple GP level patient is, I think the last time I looked, between $400 and $600 per visit per patient. This is much more expensive than the standard level b rebate, of $37.05.

I often wonder at the lack of common sense that the government financial planners have. We advised them not to fiddle with the afterhours doctors arrangements - this was ignored, and the funding for after hours care was given to Medicare locals. These are now being disbanded. The current government states that Doctors are to be paid an incentive instead to take their own afterhours calls. Now, I start work at 7 am, and finish at 5pm. Occasionally I get a call from the local deputizing service about a patient (and I worked previously full time in a local deputizing service for 3 years myself). If doctors start taking their own afterhours calls, and some already do, and will continue to do, then eventually the majority become exhausted.

I have worked in a rural setting myself also, which had 1 in 2 or 1 in 3 oncall - it is not what I would chose to go back to. Physically, it is exhausting. The government was warned that interfering with doctor organized after hours oncall arrangements had been trialled in the UK, and it was not successful. This has now occurred in Australia. Once the Medicare locals took over the afterhours care, several systems in place were dismantled and not replaced. And now the government wants the GP's to go back to the old system?. Good luck with that.

Another new government plan is to dismantle the $42 million GP helpline, which has been used by more than 200,000 people a year for advice on medications and minor health issues. This is to be axed from June 30, 2015. Again, the government was advised prior to its introduction, that a GP helpline, manned by registered nurses, would result in an increase in visits to the local A & E Departments at the hospitals. This has been proven.

Now to the PCEHR, another money waster. The current government wants to infuse another $485 million into this to "reboot" the system, with an "opt out model". Again, this has been trialled in the UK, without success, and was dumped.

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REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: **NEW DATE 28th May**

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:

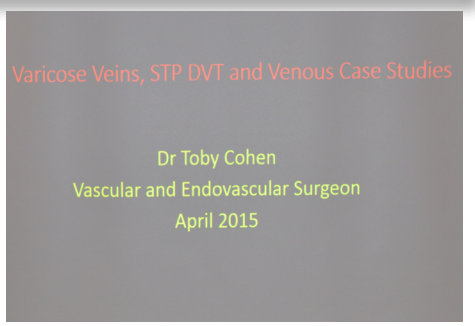
7.00pm	Arrival and Registration
7.30pm	Be seated - Entrée served Welcome by Dr Kimberley Bondeson - President RDMA Inc.
7.35pm	Sponsor: Menarinapac Pharmaceuticals
7.40pm	Speaker: Dr Roderick Chua Topic: Interesting Approaches to Cardiovascular Management.
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: Margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 22nd May 2015

QML Pathology.

RDMA April Meeting 28.4.2015

Chair President Dr Kimberley Bondeson introduced the Guest Speaker Dr Toby Cohen. Topic: Varicose Veins, DVT & STP - All Things Vascular. Sponsor for the night was Covidien



AMAQ BRANCH COUNCILLOR REPORT continued from P9
Dr KIMBERLEY BONDESON

For the final interesting piece of government planning is the new Medical School in Perth, WA at Curtain University, which has been approved. Its first intake is in 2017. But we already have a problem with too many graduates, due to the dramatic increase in medical graduates in the last few years - there is not enough training places for these young doctors once they graduate. In 2014, there were 2300 applications for 1500 GP training positions in Australia. Surely it would be more sensible to put this money into training the junior doctors we already have, instead of increasing the bottleneck?

I continue to remain optimistic; surely the government advisers and planners will ge t it right? They need to listen to clinical practicing doctors, and take sensible advice?

Kimberley Bondeson,
AMAQ Branch Councillor

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #118
Safe motoring,
doctorclivefraser@hotmail.com.

"Mini Cooper S Restoration" (Part 3)

After spending so much time, energy and money on the restoration of the Mini Cooper S it's great to see that it's finally on the home stretch. With the re-built engine installed and running it's now time to add some of the finishing touches.

45 years of UV light and wear and tear can take its toll on all of the window and door rubbers, but fortunately they are all still available for purchase at $600 for a full set. The seats have been re-upholstered and the cabin is all back in one piece at last. So it's finally time to take the Mini back out on the road.

The engine ticks over nicely and with the gearbox completely re-conditioned everything should be as good as new. But, alas there is a problem.

The gears aren't changing freely and it's necessary to double de-clutch on every change. That means slightly revving the engine in neutral to try to match the revolutions of the input and output shafts particularly when down-shifting.

How could this be? After all the Mini had a brand new clutch. Further investigation revealed that the culprit was a worn clutch pedal pivot bush.

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

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

So what was the Mini like on the road? Well frankly, just a little disappointing! It is after all a 45 year old design which lacks all of the modern engineering that makes 2015 cars feel so refined and smooth.

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

In the event of an emergency there is no ABS, no airbags or crumple zones and crashing in a Mini was never meant to be injury free.
So for a total investment which could have bought a fairly new hot hatch was the whole job worthwhile?

Well yes, I think so.

Because restoring the Mini was never about making a profit.

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

Would my friend tackle the whole job again?

He'd have to think about that.

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

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

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

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

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

1970 Mini Cooper S
Engine: 1275cc 4 cylinder OHV
Power: 45 kW @ 5550 rpm
Torque: 91 Nm @ 3000 rpm
0-100 km/h in 12 seconds
Top speed 148 km/h
7.3 l/100km
Safe motoring, Doctor Clive Fraser

Gallipoli The Story of AE2

http://www.gallipoli.gov.au/battle-of-the-landing/index.php

The Royal Australian Navy's new 'E' Class submarine, AE2, arrives at Portsmouth on 17 February 1914 to voyage to Australia. [AWM P01075.043]

The AE2 was an 'E' class submarine, a more modern craft than Holbrook's B 11. It had diesel engines not petrol, better batteries with a longer range submerged, and twice the number of torpedoes. Four 'E' class submarines had arrived to serve with the British fleet off the Dardanelles. Stoker's AE2 arrived from Australia in early March 1915. The question was, could an 'E' class vessel make the journey underwater right through the Narrows and so be able to break through and operate in the Sea of Marmara? This question became even more significant after the failure of the Allied warships to silence the Turkish shore batteries during the great attack of 18 March 1915. If there was now to be a military landing on Gallipoli, with the aim of seizing the peninsula and putting the Turkish guns out of action that way, it would be a great help to get submarines past the Narrows and operating against Turkish military transports in the Marmara. The main problem for the submarines in getting through the straits was the speed of the current at the Narrows. To make progress against it required running at full speed, which drained the battery power. Moreover, two sharp bends in the coastline at the Narrows had to be negotiated and the unpredictability of the currents there was notorious. A submarine would have to come to periscope depth frequently in order to stay on the right course.

The first to try, on 17 April 1915, was Lieutenant-Commander Theodore Brodie in E15. His ship was caught in a violent eddy off Kepez Point and forced ashore. Brodie and six of his crew were killed by a Turkish shell and the remainder of the crew was captured. Later, British gunboats sunk the submarine to stop it falling into enemy hands. After Brodie's failure, The AE2's first attempt on 23 April failed due to faulty machinery. But, on the evening of 24 April, Stoker was again given the go-ahead, being told by Admiral de Robeck that if they got through, then 'there is nothing we will not do for you'. Commodore Keys issued more dramatic instructions. Stoker was to sink any mine-laying ships he saw in the Narrows and, as the landings were due at dawn the next day, to 'generally run amok' around Çannakale and cause maximum disruption to the Turks.

At 2.30 am on 25 April 1915, as the men of the Anzac Corps approached the west coast of Gallipoli in the ships of the invasion fleet, the AE2 entered the Dardanelles. According to Stoker's report, the moon had just set and searchlights played across the dark waters: As the order to run amok in the Narrows precluded all possibility of making the passage unseen, I decided to hold on the surface as far as possible. At about 4.30 am a gun opened fire at about the 2 kilometers range … I immediately dived and proceeded through the minefield.For half an hour the crew listened as mine cables scraped the sides of AE2 and Stoker brought the submarine up through the minefield to check his position. He was aware that E15 had been caught by the currents in this area and driven ashore so he took every precaution to ensure that AE2 was well out into the channel.

At 6 am, Stoker took AE2 up to periscope depth. By that time, Australian soldiers had been ashore on the other side of the peninsula for about an hour and a half. The submarine's periscope was spotted and heavy fire opened up from Fort Chemenlik at Çannakale and from Kilitbahir on the other side of the Narrows while gunboats and destroyers began the hunt for AE2. Seeing a suitable target, the small Turkish cruiser Peykisevket, Stoker fired a torpedo and managed to submerge just before the AE2 would have been rammed by an enemy destroyer. The cruiser was badly damaged and later taken to Constantinope (Istanbul) for repairs. At this point AE2's presence became of some value to the Anzacs fighting kilometers away. A Turkish battleship, which had been firing across the peninsula at the invasion fleet causing considerable disruption, sighted the submarine's periscope and was forced to cease its shelling and move rapidly away.

By this time Stoker was north of Çannakale. He took AE2 up again and discovered he was close inshore. Suddenly, the vessel ran aground directly under the guns of a Turkish fort. Much of AE2's conning tower was showing above the surface. They were so close that Stoker could see the flashes from the enemy guns almost reaching his periscope. Luckily, the Turks were unable to depress their guns sufficiently to hit AE2 and other batteries were too far away for accurate shooting. However, Stoker and the crew spent an anxious four minutes while the submarine worked itself off the shore and shells fell all around them. They had now certainly run 'amok' in the Narrows and Stoker set off to try and get away. She again ran aground later but worked to release her again. Later, Stoker reported that during these heart-stopping moments his crew had behaved with great courage.

By this stage many Turkish ships were on the lookout for AE2. In those days the equipment did not exist for finding a submarine's position when it was submerged and it could not be attacked until it came

continued P20

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Spirituality and Advanced Cancer Patients

Patients facing serious illness like advanced cancer and its associated medical treatments experience painful emotional & spiritual struggles as they endeavour to cope with difficult changes in their lives. Families & friends are frequently challenged with these painful experiences as long relationships come to a close over shorter or longer periods of time. Grief & loss need to be dealt with in a sensitive and patient manner for those involved.

Many patients in Australia do not hold specific religious beliefs. Others follow various faith traditions reflecting the diversity of our multicultural society. Some patients, or family members, can be openly 'anti religion' and a small number elect 'not to be visited by a chaplain' in a hospital setting.

The question is 'do we need a religion to be spiritually fulfilled?' Is spirituality associated with certain religious beliefs?

As a Medical Oncologist and Palliative Medicine Physician, I see patients during their whole journey of cancer, from diagnosis to active treatment to palliation. Many times I see complete transition of thoughts or belief patterns of patients during this difficult journey. A religious patient becomes anti-religious, as he/she can't accept why they got incurable cancer and are in constant emotional/spiritual pain. At the same time, a patient not believing in any religion has total peace in his/her heart with facts of advanced disease and limited prognosis and enjoying every day of life left. Religion not necessarily provides spiritual growth.

Good pastoral and spiritual care can assist the human spirit as ongoing crisis can leave people spiritually exhausted or impoverished. Confidence and feelings of self-worth can be undermined as patient's health deteriorates and families suffer. Demanding personal problems and life situations can deplete resources as well. Patients may need to speak about emotional & spiritual wounds such as long running family disputes which have not been resolved and require 'healing' or 'reconciling'. Simply listening in an attentive manner in a posture that shows interest in the person's need to talk can offer comfort to many patients.

I will tell story of two of my patients. Both have advanced cancers reaching to a line where no further chemotherapy can be offered. Both are young, have limited prognosis and dealing with complex social issues. Both have quite extensive disease, which can give lots of symptoms particularly pain. One is on minimal dose of morphine. Every time he comes to clinic, he is always joyful and happy. One day I asked him what makes him to stay in good mood all the time. The answer was astonishing. He told me he has something glowing inside, which doesn't let him feel sad. A bird chirping on the tree branch or dew on grass leaf makes him feel happy and joyful. His pain medication is on stable dose for quite sometime now. The other patient is on high doses of morphine for pain. Every time, half of the consultation goes in listening to his complaints towards how life being unfair to him and how family not supporting him. Doses of analgesics are going up regularly.

These experiences make us think how important spiritual growth is in our lives. The situation doesn't change. Its all about how we handle it and how much internal peace we can develop not only during difficult situations but in our daily life. Spiritual upliftment of medical professionals helps them from burnout and helps them to care their patients more efficiently.

Estate Planning

In our article last month we highlighted the family estate planning record keeping and document storage processes and reinforced the importance of a Will and speaking to your executor and your family about your wishes.

A well planned Will can give your family peace of mind knowing that in the event of your death you have minimized tax, protect the estate from being successfully contested as well as providing clear instructions for your grieving family.

To illustrate whether you are on the right track, we have done a simple case study which highlights important issues . We have had input from 3 professionals, solicitor, financial planner and accountant.

Facts.

Dr Dunlop was married to Elsa with 1 child Frank 19yo who is at Uni and receiving financial support. Dr Dunlop was a joint owner with Elsa of his principal residence (owned prior to 20.09.1985 pre CGT). He owned solely a rental Property purchased in 1992.

Dunlop & Crawford Medical Pty Ltd – employed GP's and earnt all medical income including owing all equipment. Dr Dunlop and Dr Crawford were joint directors and owned half of the shares each.

He was a member with Elsa of his own Self Managed Super Fund – Dr & Mrs D Pty Ltd ATF Dunlop Super Fund. Life insurance and ASX listed shares were held inside super.

His wishes were to leave only the residence to Elsa, all other assets are to go directly to his son.

Below are 3 viewpoints of important factors to consider in the preparation of your Will:

Legal Advice (Solicitor Trent Wakerley – Associate Kruger Law – 5443 9600)

1. Is the principal residence owned as "joint tenants" (passes straight to the survivor) or as "tenants in common" (forms part of the estate and is governed by the Will)?;
2. What does the company constitution of Dunlop & Crawford Medical Pty Ltd and Dr & Mrs D Pty Ltd say about appointing replacement directors and giving shares to other people when the shareholder dies?;
3. What do the rules of the superannuation fund say about death benefit nominations (i.e. can Dr Dunlop control whether his superannuation forms part of his estate or not)?;
4. Has Dr Dunlop considered Elsa's ability to contest the Will if she isn't satisfied with what she has been provided with?;
5. Is a testamentary trust appropriate for the gifts to Frank?

Financial Planning Advice (Kirk Jarrott Partner – Poole & Partners Investment Services – 5437 9900)

1. Continue to review ownership of Life insurance policies. Once Frank is no longer financially dependent he will not be classed as a dependent under the tax act, hence if Dr Dunlop passes away at this point any life insurance proceeds could attract upwards of 31.5% tax. Dr Dunlop does have the option to change the ownership of his life policy to his own name outside of super to avoid any tax payable by Frank once Frank is no longer financially dependant. If Dr Dunlop wishes to continue to hold the insurance via his SMSF, the level of cover could be increased to account for the expected tax.
2. Although Dr Dunlop wants to leave all other assets to his son, part of his assets include the ownership of the medical practice. I'm sure Dr Crawford does not want to be in business with Frank especially when Frank has no qualifications as a doctor. Therefore, a legal buy/sell agreement should be in force which instructs the transfer of Dr Dunlop's shares in the medical centre to be transferred to Dr Crawford and vice versa if there is a trigger event, e.g. death or permanent disability. Separate insurance should be in force to support the value of the practice which would be paid to Dr Dunlop's nominated beneficiary in the event of a claim.

Tax Advice (Kerri Welsh Manager – Poole & Partners – 5437 9900)

1. The tax treatment of Real Estate received as part of an estate varies and is dependant on a number of factors i.e. is the real estate pre or post CGT? Is the intention to hold the Real Estate after the death? If yes, for how long? Was a valuation taken at Date of Death? Will the asset be income producing?
   Capital Gains Tax in the hands of the beneficiary may be unavoidable but a market valuation taken at Date of Death can substantially reduce the burden.
2. Super – from a tax perspective Frank is still receiving Financial support as the beneficiary of the will his entitlement in the Super Fund would be tax free. If he was not receiving financial report he would pay tax at 31.5%.
3. The transfer of the share in the medical practice is a CGT event. It needs to be carefully considered how the valuation of the practice is calculated and type of insurance in force so as to minimise the tax to the family pool of assets. It would be a difficult situation to resolve once Dr Dunlop is passed as to the valuation method for the Medical Business and the buyout from Dr Crawford. By putting a strategy in place early all parties including Dr Crawford are aware of the outcome in event of death of one of them.
4. As the trustee of the SMSF is a company the constitution should allow for a sole director and no offmarket transfer of shares would be necessary. If they had of been individual trustees the situation would have required the immediate appointment of a second trustee on Dr Dunlop's death and action to update the trustee name on all assets owned by the SMSF.

Should you wish to talk to any of the contributors in this article we would be happy to discuss so please call us.

Next month we would be happy to answer any questions you may have on the topic, please keep questions to the point and email by 31.05.2015 to Kwelsh@poolegroup.com.au .

Media Release

19 May 2015

Medical students project major shortage of internship places for 2016

The Australian Medical Students' Association (AMSA) is expecting that up to 400 graduating medical students will be without an internship position in 2016.

AMSA President, James Lawler, said, "There is a crisis in medical training, and it will only get worse in 2016.

"For a graduating medical student to become a fully-qualified doctor, they first need to complete a mandatory internship year in an Australian hospital."

Based on data from the 17th Medical Training Review Panel report to government, there will be 3,732 medical students graduating in 2015. However, figures from States and Territories show there are expected to be only 3,226 internship positions next year, plus an extra 100 provided by the Federal Government's Commonwealth Medical Internships Initiative.

Mr Lawler further states, "These students have studied for up to seven years in Australia and failing to provide them with an internship means they will need to look overseas to complete their training."

"There were also hundreds of applications to specialist training programs last year which were unsuccessful due to insufficient capacity, including 800 in General Practice.

"Modelling from the recently disbanded Health Workforce Australia indicates that there are more medical graduates than there are training opportunities.

"There will be over 1,000 graduates unable to find training positions by 2030 [without taking into account graduates from the new Curtin Medical School].

"This means that a significant number of junior doctors who have completed medical school will be unable to become fully qualified.

"In light of these figures, AMSA finds the Prime Minister's $20 million commitment to build a new medical school at Curtin University bizarre.

"The Prime Minister should withdraw his $20 million commitment to Curtin medical school immediately and redirect the funding to postgraduate medical training."

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NEW YORK, A CITY OF DREAMERS

By Cheryl Ryan

With the beautiful architectural marvels, cuisines from every part of the world, friendly people and exciting nightlife, New York spreads its arms for everyone. It's a city of trendsetters; a heaven for art lovers; a capital for businessmen; and a home to millions from all over the world.
Acknowledged as the World City, New York is a cosmopolitan city with modern amenities and rich cultural diversity that caters to everyone with varied tastes of holidays!

What New York City has got in store for you?

Art & Culture
New York is home to one of the best art museums in the world. The major museums are Metropolitan Museum of Art in Central Park, Museum of Modern Art in Midtown and Brooklyn Museum of Art with collection of finest paintings and artifacts from American, European and Islamic cultures. The city also has American Museum of World History in Manhattan with a vast collection of astronomical exhibits, rare mineral specimens and dinosaur skeletons.

Food Haven
New York is also known as the 'City of Restaurants'. With its more than 20000 dining restaurants and bars, the city offers all the cuisines of the world to suit all tastes and budgets. New York is one of those places which has got ample options for vegetarians at its hundreds of vegetarian only restaurants. It also boasts of street food culture, famous for authentic American cuisines like Bagel, Hot Dog, Sandwiches and Falafel with an added distinctive New York character.

New York Attractions
The city is home to some of the world's most famous, recognizable landmarks which complete New York City. The list of these iconic landmarks and exciting attractions includes Statue of Liberty, Times Square, Brooklyn Bridge, Empire State Building, Rockefeller Center and Central Park among many others which tops the must-see list of every tourist coming to the city.

New York Nightlife
New York is a city which never sleeps. When Sun goes beneath the horizon and the skyline is lit by tall skyscrapers, New York comes out to witness the life of theaters and performance arts. The city is known for its experimental theatre concepts, avant-garde fashion, embracing world music and as a stage for upcoming performers. The city boasts of famous Broadway theatres, Opera theatres at Lincoln center and Dance shows, Music concerts at venues across the town.

What we have planned for you?
A detailed itinerary has been developed, including all must-see places and must-do activities, to make your visit to the City of Dreams, a memory of lifetime.

- Visit to the Museum of Modern Art and American Museum of World history, to witness the artistic and scientific marvels of human race
- Visit to Statue of Liberty, Times Square, Central Park and Empire State Building
- Food walk in the Boroughs of New York, relishing the taste buds with street foods from every corner of the world
- No trip to New York is complete without experiencing the cosmopolitan night life culture….a visit to Broadway theatre and Marquee New York – a club with all night long parties to end your exciting trip!

Book today to visit the World City of New York!

Cheryl Ryan 123Travelconferences

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PHARMACY AGREEMENT: PHARMACISTS FLUSH WITH FUNDING WHILE DOCTORS AND PATIENTS GET FROZEN OUT

AMA Vice President, Dr Stephen Parnis, today questioned the Government's decision to dramatically increase funding to the pharmacy sector under the Sixth Community Pharmacy Agreement, while doctors and patients are subject to a Medicare patient rebate freeze until 2018.

Dr Parnis said that pharmacy will receive a guaranteed 4.54 per cent increase each year for five years, while medical services get zero increase for the next three years.

"The handout to pharmacies also includes an extra $600 million for 'support programs for patients'," Dr Parnis said.

"This is a lot of money for programs that are yet to be devised. We have seen past proposals and worry about fragmentation of patient care because these pharmacy 'services' may not add any value to patient outcomes.

"The Health Minister said today that the Government wants pharmacists to play a greater role in the patient's 'medical team' - but pharmacists are pharmacists, not doctors.

"Pharmacists are not medically trained to provide medical services, nor are they indemnified to do so.

"The best primary care is provided by the local family doctor, the GP – the most cost-efficient part of the health system.

"The Government has its health priorities all wrong.

"Patients have been hit with a Medicare rebate freeze until 2018.

"Public hospital funding to the States has been cut dramatically.

"More health programs and services suffered funding cuts in last week's Budget.

"But the pharmacy sector gets a huge funding boost with no questions asked," Dr Parnis said.

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18 May 2015

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NEW ARRANGEMENTS WILL IMPROVE AFTERHOURS GP SERVICES

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA welcomes the changes to funding for After Hours GP services announced today by Health Minister, Sussan Ley.

AMA President, A/Prof Brian Owler, said the Minister consulted closely with the profession and decided to return funding to the Practice Incentive Program (PIP) for After Hours GP services, as flagged in last week's Budget.

"We are pleased that the Minister has moved swiftly to implement the Budget announcement, with the new arrangements starting on 1 July," A/Prof Owler said.

"The AMA has been calling for the return of the PIP funding for some time.

"The new PIP payment structure will encourage and support general practices to provide After Hours coverage for their patients, which will in turn ensure continuity of care.

"The Government has listened and responded to AMA concerns about giving responsibility for After Hours funding to Medicare Locals, which has proven to largely be a failure and simply increased red tape for practices.

"While the new Primary Health Networks (PHNs) will still have a role to play in ensuring community access to After Hours health services, their focus will be on gaps in service delivery.

"Individual practices will now have greater control over After Hours services for their patients.

"The Government and the Minister are to be commended for this decision. Patients will benefit," A/Prof Owler said.

22 May 2015

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Annual subscription is $100.00. Doctors-in-training and retired doctors are invited to join at no cost. 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/ or speakers are most welcome.

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Where We Work And Live

Gallipoli The Story of AE2

up. On the other hand, submarines passing through the Dardanelles needed to surface frequently to take accurate course bearings from nearby landmarks, otherwise risked running aground. Feeling he had sufficient data for his course, Stoker headed AE2 down the straits past Nara Burnu at some depth before he risked further necessary observations at periscope depth. Coming back up, he saw they were well past the point but the Turks saw them. Fire was reopened upon the submarine and the chase resumed. When they surfaced again Stoker saw straight ahead two Turkish tug boats with a wire stretched between them to catch the submarine's conning tower. Down AE2 went yet again. Stoker took it to the bottom and settled the vessel there with the engines off. They did not have enough power left in the batteries to get right through to the Sea of Marmara and to recharge them would require running on the surface under diesel power. It was 8.30 am, 25 April 1915. As the Anzacs tried to find their way forward on Gallipoli, sailors of the Royal Australian Navy were almost through the Dardanelles.

April 25 1915 was a Sunday. As the AE2 rested, Stoker held prayers and then gave the crew a chance to sleep. Overhead they could hear the Turks looking for them and at one point something being towed from the surface hit the side of the vessel. Leaks were bringing significant amounts of water into the bilges and this water, if pumped out and released, could reveal their position because it contained large amounts of oil. All day the crew worked carrying water to a safer place in the submarine.

At 9 pm Stoker finally brought AE2 back to the surface. They had spent more than 16 hours underwater, it was dark and no ships were in sight. So stale had the air become that in some areas of the submarine a match would not burn for more than a fraction of a second. The crew, when permitted, now hurried up top for gulps of fresh air. Stoker placed the submarine on diesel power and moved ahead charging the batteries. Again and again the AE2's wireless operator beamed a message back to the invasion fleet to say they had made it through the Narrows and were heading for the Marmara. No answer was received and AE2 ran on into the night.

But AE2 had been heard and the news of its success conveyed to the top navy and army commanders. After the war Stoker was told by Admiral Roger Keys of the dramatic effect the news had had as General Sir Ian Hamilton was pondering the fate of the Anzacs on Gallipoli. One Australian soldier ashore that night claimed later that the following message was posted at Gallipoli: Australian sub AE2 just through the Dardanelles. Advance Australia.

Actually, another submarine had got through. On the night of 27 April, Lieutenant-Commander Edward Boyle took HM Submarine E14 up the Dardanelles. The two captains agreed to rendezvous next day, 30 April, at 10 am. As AE2 cruised underwater it suddenly began to rise upwards, out of control. The submarine had hit swirling patches of denser water causing it to lose its capacity to hold balance or 'trim'. Although Stoker ordered full speed downwards, the submarine ascended and was fired on by the Turks but then dived below safety limits. Stoker now ordered full speed astern and blew air into his main tanks. Slowly AE2 responded but then it ran back up until it broke surface in full view of the Turkish torpedo boat, the Sultanhisar. Stoker, determined not to let his submarine fall into enemy hands, recorded the last minutes of the AE2: He blew the main ballast and ordered all hands on deck. Assisted by Lieutenant Cary Haggard, he opened all tanks to flood the sub. A shout from Cary 'Hurry, Sir She's going down' and we clambered up. The AE2 went down at 10.45 am on 30 April 1915 and slid to the bottom of the Sea of Marmara about six kilometers north of Kara Burnu. Stoker and all his crew were captured and held in a POW Camp for 3 years.

Lieutenant Henry Stoker and two other officers of the AE2 in captivity in Turkey between 1915 and 1918. [Photograph from Henry Stoker, Straws in the Wind, London, 1925]

The submarine war in the Marmara did cause havoc with vessels like the AE2, E11 and E14 'completely disrupting' Turkish sea communications, forcing reinforcements overland taking much longer to reach the front lines on Gallipoli. Food and other stores still brought by sea, but in small ships were forced to hug the coast and move only by night. It was unanimously agreed by the Turks because of the submarines the supply of their armies on Gallipoli was, for the whole of the campaign, an 'acutely anxious problem'. The German assessment was also clear on the outcome if the British had been able to bring considerable numbers of submarines through the Narrows: In this Allied attack on the Turks, the AE2 had led the way. On 12 November 1918 the British 5th Destroyer Flotilla sailed through the Dardanelles bound for Istanbul. With the fleet were warships of the Royal Australian Navy, HMA Ships Yarra, Torrens, Warrego and Parramatta.