RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
SEPTEMBER 2014

The Henry Miller Trail

See the Henry Miller Trail Self Guided Walk Historical Article in Where We Live And Work segments page 20

The Henry Miller Trail Self Guided Walk. Follow the trail of the first European Settlers in Queensland 1824. It only takes an hour from the First Settlement Wall to the Redcliffe Museum. Important landmarks are:

1 FIRST SETTLEMENT MEMORIAL Built with 50 tonnes of bluestones to a design representing the sails of the Amity, the Wall was opened in September 1991. There monument honours the First Settlement of 1824 and first inhabitants the Ningy Ningy clan of the Undambi tribe.

2 NORFOLK PINES (CAPTAIN COOK PARK) The Norfolk Pines, which planted along the foreshores of Redcliffe in 1947, are an ornamental conifer native to Norfolk Island.

President's Message Dr KIMBERLEY BONDESON

Thank you all once again for allowing myself, Dr Herdy, Dr Fry and Dr Stephenson the opportunity to continue to work as the Executive Committee for the Redcliffe and District Medical Association.

We would also like to acknowledge our close association with North Side LMA, Dr Bob Brown, Dr Graham McNally, Dr Ian Hadwin and of course, again, Dr Ken Fry.

QML continues to support both the Redcliffe LMA and the North Side LMA, with our meeting convenors who are well known to many of us, Margaret MacPherson, and Lucy Smith, and which these meeting could not do without. And our publisher, Karen Bond, who spends several hours each month, putting together our newsletter.

Plans for the coming year are simple; to continue to advocate for our colleagues and our patients and to monitor what the government is attempting to do. For example introduce the $7 co payment. Of interest, the Federal AMA had put forth an alternative plan, introducing a $6.15 copayment but without the constraints which the government has suggested and without the cuts to GP's PIP payments or rebates.

This would allow the GP to consider their patients' circumstances, and exempting pensioners, children, nursing home patients and other vulnerable groups.

It is with interest that we continue to watch and see what unfolds. To date, the government's response has been luke warm, to say the least.

Now, onto immunizations – the new Meningococcal Vaccination against Meningococcal B is now available in Australia but is not publically funded, nor on the PBS. Boostrix is back in the immunization schedule for pregnant females, from K28/40.

Kimberley Bondeson,
RDMA President

RDMA & NLMA's Joint Newsletter

WELCOME FROM

President Northside Local Medical Association

Dr BOB BROWN

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

RDMA Executive Contacts:

President:
Dr Kimberley Bondeson
Ph: 3284 9777

Vice President & AMAQ Councillor:
Dr Wayne Herdy
Ph: 5476 0111

Secretary:
Dr Ken Fry
Ph: 3359 7879

Treasurer:
Dr Peter Stephenson
Ph: 3886 6889

Meetings' Convener:
Mrs Margaret MacPherson
Ph: 3049 4444

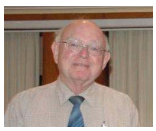
Newsletter Editor: Dr Wayne Herdy
Ph: 5476 0111

Advertising information is on RDMA's website
www.redcliffedoctorsmedicalassociation.org/
please contact **Newsletter Publisher.**
Email: RDMAnews@gmail.com
Mobile: 0408 714 984

NLMA Executive Team Contacts

President:
Dr Robert (Bob) Brown
Phone: (07) 3265 3111
Email: drbbrown@bigpond.com
C/- Taigum Central Medical Practice,
Shop 1, 217 Beams Rd, Taigum Qld 4018

Vice President:
Dr Ken Fry
Phone: (07) 3359 7879
Email: kmfry@bigpond.com



Treasurer:
Dr Graham McNally
Phone: (07) 3265 3111
Email: gmcnally1@optushome.com.au
C/- Taigum Central Medical Practice,
Shop 1, 217 Beams Rd, Taigum Qld 4018

Secretary
Dr Ian Hadwin
Contact Details;
Phone: (07) 3359 7879
Email: hadmed@powerup.com.au

Convener:
Lucy Smith, QML Marketing Office,
Phone: (07) 07 3121 4565.,
Fax: (07) 3121 4972
Email: Lucy.Smith@qml.com.au

RDMA & NLMA Newsletter Publisher.
For all enquiries, editorials, advertising contributions & costs
Email: RDMAnews@gmail.com
Mobile: 0408 714 984

RDMA 2014 MEETING DATE CLAIMERS:

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 25th
Wednesday	March 26th
Wednesday	April 30th
Tuesday	May 27th
Tuesday	June 24th
Wednesday	July 30th
Tuesday	August 26th AGM:
Wednesday	September 17th
Next Tuesday	October 28th Date Change
NETWORKING:	
Friday	December 5th

RDMA NEWSLETTER DEADLINE

Advertising & Contribution is 14th October 2014
Email RDMAnews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

NLMA 2014 Bi-MEETING DATE CLAIMER:

For all Northside LMA Meeting & Membership queries contact:
Meeting Convener:
Lucy Smith , QML Marketing Office,
Contact Details;
Phone: (07) 3121 4565, Fax: (07) 3121 4972
Email: lucy.smith@qml.com.au
Website and Link:
Northside Local Medical Association Website
Link: http://northsidelocalmedical.wordpress.com/

Meeting Times: 6.45 pm for 7.15 pm

2014 Dates:

1	11th February 2014	4	12th August 2014
2	8th April 2014	5	14th October 2014
3	10th June 2014	6	9th December 2014

INSIDE THIS ISSUE:

Narangba Family Medical Practice

Job Vacancy

A part-time *(with view to full time if required)* VR Family Doctor for the Narangba Family Medical Practice (www.narangba-medical.com.au) as one of our doctors (Dr. Orr) has left to specialise.

We are a three doctor, fully computerised, non-bulk-billing practice established since 1986 in an outer, semi-rural northern suburb of Brisbane. The ideal candidate would be of an age where taking over the whole practice eventually would be a distinct possibility.

Contact: Dr Peter C. Stephenson,
Email: PCS1@narangba-medical.com.au
Mobile: 0403 151 602.

Practice Phone & Location: Phone: 07 3886 6889, Opposite the Narangba Railway Station, Main Shopping Centre, beside the Narangba Pharmacy.
Street Address: 30 Main Street, Narangba Q 4504.
Postal Address: P.O. Box 3 Narangba Q 4504

HANDFORD ROAD MEDICAL CENTRE
41 - 45 HANDFORD ROAD
ZILLMERE QLD 4034

DR LARRY GAHAN P/N 353106J
M.B.,B.S. (Qld) F.A.C.A.M.
DR CAROLE GAHAN P/N 352736J
M.B.,B.S. (Qld)

Job Vacancy

- **PT/FT VR GP – FRACGP Preferred**
- **Brisbane North- Zillmere**
- **Busy well established ethical practice**
- **Accredited,**
- **Computerised,**
- **Friendly,**
- **Noncorporate**
- **Your own consulting room with natural light**
- **No after hours or weekends**
- **Environs Bus-stop, Rail station, 2 pharmacies, QML & S&N**
- **Mixed Billing,**
- **Start with high percent,**
- **View to Associateship if desired**
- **Non DWS**

Contact: Dr Larry Gahan,
Email: larryg82@hotmail.com
Phone: 07 3265 7500

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Caboolture QLD Area

Existing patient's base and equipment to give away

Excellent opportunity and potential in growing area

Ph: 0411187515 or 0411608124

AUSTRALIAN MEDICAL ASSOCIATION QLD PRESIDENT
Dr Shaun Rudd

Dear members,

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

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

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

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

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

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

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

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

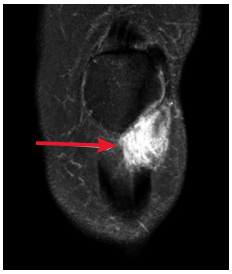
It is hard to believe the year is 2/3 of the way over. The last few months of the year are always a busy time at AMA Queensland with our Annual Conference, Intern Workshops and Events and our Private Practice Series. I hope you'll take advantage of these offerings and I look forward to what we'll be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

Sincerely,
Dr Shaun Rudd
AMA Queensland President

MORETON BAY RADIOLOGY

Patellar Tendon Lat Fem Cond Friction

Findings
Diffuse oedema is demonstrated within Hoffa's fat pad between the patellar tendon and lateral femoral trochlea.



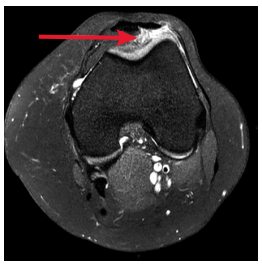
Diagnosis
Findings are in keeping with patellar tendon lateral femoral condyle friction syndrome.

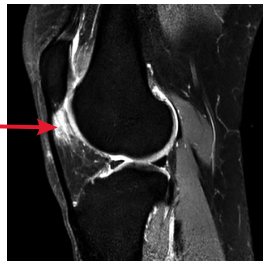
Discussion
Patellar tendon lateral femoral condyle friction syndrome is a common cause of anterior knee pain in active individuals. It is thought to be due to patella maltracking causing impingement of the superolateral aspect of Hoffa's fat pad between the inferior patella and the lateral femoral condyle. The condition is also known as Hoffa's fat pad impingement syndrome.

Clinical presentation
Patients present with anterior knee pain exacerbated by hyperextension, and with point tenderness at the inferior pole of the patella. The fat pad is thickened which may make palpating the patella difficult.

Radiographic features
It is usually occult on radiographs and CT.

MRI
Focal area of high T2 signal (oedema) at the inferolateral aspect of the patellofemoral joint, within the superolateral portion of the infrapatellar fat pad. A cystic lesion can sometimes be found between the lateral femoral condyle and the lateral retinaculum. Associated findings include lateral patellar subluxation and patella alta (Insall-Salvati ratiogreater than 1.2) which are found in around 90% of cases.





REFERENCES
http://radiopaedia.org/articles/patellar-tendon-lateral-femoral-condyle-friction-syndrome

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

WOULD COPAYMENTS MAKE ETHICAL RATIONING POLICY?

During the World Wars, there were shortages of most consumer products. In Australia, that was either because items such as petrol were fully imported, or because there was a shortage of labour to produce items such as food. Governments introduced frank rationing. Individuals were issued with ration cards that allowed them to buy basic essentials – many foods, clothing, and petrol – but only in limited and prescribed amounts.

The ration card was a permit to purchase, and the consumer still had to pay for the product, if they had enough money. Many ration cards remained unused, either because the consumer did not perceive that they needed the item that the government thought they needed, or because they could not afford it anyway.

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

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

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

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

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

Patients who avoid the cost of GP consultations might be those who genuinely can't afford it, but will include many who can afford the cost but just refuse to pay for a service that they are accustomed to receiving without direct cost. In the longer term, there is a possibility that, when patients become accustomed to the presently-unfamiliar idea that all patients will make a contribution to the cost of a consultation, they will revert to a rate of consumption not much different from the present rate of consumption.

If so, the rationing will fail. The final outcome will be similar rates of GP attendances to present rates, but at lower unit cost to the government and higher cost to individual patients.

Thirdly, an ethical rationing process will ensure that access to GP services will be dictated by need, not by ability to pay. In the initial proposals, the GP co-payment was going to strongly favour those with deep pockets and substantially exclude those with limited financial means.

Ration cards were issued in wartime to those who most needed the scarce resource – babies could preferentially get milk

AMAQ Branch Councillor Report by Wayne Herdy

Continued from Page 6

when others could not. The co-payment proposal was going to achieve the exact opposite – patients with chronic disease and disadvantages would experience greatest difficulty getting access to health resources even though their real need is undeniably greatest.

Even the AMA alternative, to simply exclude disadvantaged groups from the co-payment, would not satisfy rationing theory. Ethical rationing would create an environment in which those who most need GP services would not merely be exempted from the rationing barrier, but would have positive assistance in getting access to health services.

In its purest ethical form (shorthand for saying that this will probably never happen) rationing of GP services would give priority to those with proven greatest need, and limit the amount of those services consumed by those whose real need is not so great.

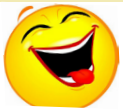
So, what is the answer to the question at the head of this article? A resounding "no". Apart from what we have already speculated as practical outcomes to implementing co-payments, the policy also fails the abstract theories underlying the philosophy of rationing.

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

Wayne Herdy
Branch Councillor
North Coast Area Representative

Interesting Tidbits NATTY MOMENTS:

Funny Corny Jokes



A woman brought a very limp duck into a veterinary surgeon and laid it on the table. The vet pulled out his stethoscope, listened to the bird's chest and informed the woman that her duck was dead. The distressed woman wailed, "Are you sure? I mean, you haven't done any testing on him or anything. He might just be in a coma.

The lab walked to the examination table and the dog sniffed the duck from top to bottom. He then looked up at the vet with sad eyes and shook his head. The vet patted the dog on the head and led it out of the room.A few minutes later he returned with a cat. The cat jumped on the table and also delicately sniffed the bird from head to foot. The cat sat back on its haunches, shook its head, meowed softly and strolled out of the room.

The vet looked at the woman and said, "I'm sorry, but as I said, this is most definitely a dead duck." The vet turned to his computer terminal, hit a few keys and produced a bill, which he handed to the woman.

The duck's owner, still in shock, took the bill and screamed, "$150! Just to tell me my duck is dead?" The vet shrugged, "I'm sorry. If you had just taken my word for it, the bill would have been $20, but with the lab report and the cat scan, it's now $150."

A woman accompanied her husband to the doctor's office. After his checkup, the doctor called the wife into his office alone. He said, "Your husband is suffering from a very severe stress disorder. If you don't follow my instructions carefully, your husband will surely die.

"Each morning, fix him a healthy breakfast. Be pleasant and don't upset him at all; it will only make his stress worse. Do not nag him. Most importantly, make love to him regularly. "If you can do this for the next 10 months to a year, I think your husband will regain his health completely." On the way home, the husband asked his wife, "What did the doctor say?" "He said you're going to die," she replied.

~~*~*~*~*~*~*~*~*

AMAQ BRANCH COUNCILLOR REPORT
GREATER BRISBANE AREA
Dr KIMBERLEY BONDESON

AMAQ Annual Conference

As you may have noticed, this month's meeting is earlier than normal. This is because myself (and others) are attending the Annual AMAQ Conference in Capetown, South Africa.

This year, the conference is entitled "Health has a Postcode (Social Determinants of Health)", something which I think all doctors are aware of.

This theme is being carried through by the AMA and AMAQ in its comment on the "Policy makers on all sides for playing at health system reform without promoting sustainable general practice" (Medical Observer, page 1, 5th September, 2014).

As Doctors, we try to protect the vulnerable, aged and financially destitute – often this is "associated with a postcode", not just in the international and third world arena, but in Australia.

In the same article, Professor Owler addressed Mr Dutton at the AMA's annual parliamentary dinner in Canberra that "While the government's co-payment plan has a $480 million windfall for GPs, Minister, I note that the AMA's plan has a $580 million cash grab.

"This is not about getting more money for GP's – and many of you will take that how you like. It is not a pay rise. It is an investment in general practice – more staff, new equipment, technology, better premises." (Medical Observer, page 2, 5th September, 2014).

Dr Kimberley Bondeson
AMAQ BRANCH COUNCILLOR

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION MEMBERSHIP

Attendance at the Redcliffe & District Medical Association (RDMA) Meeting is **FREE** to current RDMA members.

Doctors are welcome to join on the night and be introduced to the members. **Membership application forms are in this edition and available at the sign-in table on the night.**

Meeting dates are in the date claimers on page 2
COST for non-members:
$30 for doctor, non-member

CHANGES TO CLASSIFIEDS

Classifieds remain **FREE** for current members. To place a classified please email: RDMAnews@gmail.com with the details for further processing.

Classifieds will be published for a maximum of three placements.

Classifieds are not to be used as advertisements.

Members wishing to advertise are encouraged to take advantage of the Business Card or larger sized advertisement with the appropriate discount on offers.

Letters to the Editor

ETHNICITY & ACCREDITATION BY DR MAL MOHANLAL

Do you know that classification of patients' ethnicity is now a requirement in the current triennium for practice accreditation? Because I believe this process conditions the mind negatively I have written to the CEO of AGPAL, Dr Stephen Clark and the president of RACGP, Dr Liz Marles explaining why the medical profession should not be involved in this data gathering process. In the meantime all the staff in our practice has been instructed to ignore this requirement. I would think most doctors will agree with my sentiments and will do the same. Here is the letter:

"Dear Dr Clark

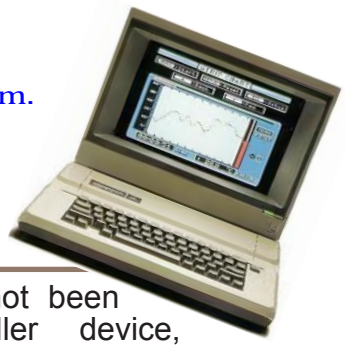
RE: ETHNICITY OF PATIENTS IN ACCREDITATION REQUIREMENTS FOR THE CURRENT TRIENNIUM

Continued Page 12

COMPUTERS & GADGETS

Email: apndx@hotmail.com.

with Doctor Daniel Mehanna



"The Empire Strikes Back"

Everyone loves a great battle. Whether it be Luke Skywalker against Darthvader, Tony Abbott against Bill Shorten or Apple against Android.

After Apple released the IPhone those many years ago (can anyone still remember the time before smart phones?) the world of consumer electronics changed forever. Apple released a revolutionary, polished and most importantly easy to use product that simply amazed consumers.

Since then, however, the mighty empire of Apple has been under siege. Android has fought back by a very simple, pragmatic and effective strategy. A technique that funnily enough was the same strategy they Microsoft used (with great effect) against Apple in the PC wars of the 1980s. Android made their operating system open source and free to all the phone manufacturers to use. The phone manufacturers in turn were free to do with it what they thought would work best. They released a whole variety of phones to suit every budget and requirement in an effort to grab market share. At first it had little effect against Steve Jobs' "reality distortion field". The Apple product not only was a better product but from a marketing point of view was seen as cool, hip and the phone to have. The Apple Empire resisted.

But over time, through subsequent improvements of the Android operating system with accompanying advances in the phone hardware Android caught up. The Android Empire countered with bigger screens, better resolutions, faster processors, wireless charging, near field communication (NFC) and more operating system features. Not only that, but Samsung cleverly ramped up their marketing strategy to match Apple's to make Samsung's phone just a cool as Apple's. This combined with the unfortunate death of Apple's Emperor Steve Jobs has put Apple firmly in the back seat for the past several years. Since his death there has not been a killer device, an exciting product or a "one more thing" moment (this is the comment the late Steve Jobs would offhandedly make almost as an afterthought to the Apple faithful just before releasing a revolutionary product).

Thankfully however Apple has now struck back. It has released new phones with much improved features including bigger screens, faster processors and finally a near field communication chip. And the world is a better place. You see, it is not only in the best interest of Apple to release great products but of also the Android users. Competition is great for everyone and we will all benefit regardless of whether we have an Apple phone or not.

You see, it doesn't really matter if many of the features released by Apple have been in the Android arsenal for years. Apple will do what Apple does best. It will polish them, make them user friendly and by virtue of Apple's marketing power, make them just work.

A case in point; near field communication. Sure, Android has had it for several years (my Nexus 4 released 2 years ago had it) but it simply did not gain the traction as retailers and the rest of the market essentially ignored it. Hopefully now that Apple has joined the party we (all phone users) will be able to easily pay for goods at the shops with our mobile phone. And hopefully this will be just the start. Stirred by Apple's introduction of NFC, a multitude of uses will finally spring up. The Smartphone will hopefully replace the humble car key and maybe even the house keys. The only limit will be our imagination. And if anyone can make the smartwatch work, it will be Apple.

And that's why we all should be happy that the Empire strikes back.

RDMA August Meeting 26.08.2014 Sponsor: MSD

Pharmaceuticals. Chair President Dr Kimberley Bondeson Speakers: Dr Anita Sharama
Topic: 2014-2015 RACGP General Practice Management of Type 2 Diabetes: A Review

LEFT: Sponsors: MSD Pharmaceuticals Trisha Kerrin & Rob Tabuteau.

CLOCKWISE; Ambika Bhasin, Anita Sharma (Speaker) & Max Wilson.

Re-elected Executive Team: Treasurer Dr Peter Stephenson, Secretary Dr Ken Fry, Vice President Dr Wayne Herdy and President Dr Kimberley Bondeson.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: **Wednesday 17th September**

Time: 7 for 7.30pm

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

Cost: Financial members - FREE, Doctors in training - 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: Monserrat Day Hospital North Lakes
7.40pm	Speaker 1: Dr Shamsul Islam Topic: H. Pylori infection - the tricky aspects
	Speaker 2: Dr Darshit Arunbhai Thaker Topic: Cancer Screening, what's new? With focus on advances in Breast Cancer Screening
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 12th September 2014

QML Pathology.

Letters to the Editor Continued from Page 9

ETHNICITY & ACCREDITATION Cont
BY DR MAL MOHANLAL

My staff recently pointed out to me that the latest version of Medical Director and Pracsoft has boxes to tick and classify patients according to their ethnic background. This I am told is one of the requirements in the accreditation process of the current triennium.

I do not know whether you realize it or not, but this in my mind constitutes a serious breach of individual privacy. To use the medical profession as a tool to gather information about patients' ethnicity is quite abhorrent to me although I realise that you may want this information to be used for scientific research.

Ethnicity is a sensitive issue and the data collected can be used in so many different ways. When we emphasise ethnicity it can become a divisive issue. When we label people according to their ethnic background we can easily stereotype individuals as people do with bipolar and schizophrenic disorder. Various prejudices can arise against people according to their ethnicity.

As such this data collected can be used to discriminate against people with certain ethnic background. Why should the medical profession be involved in this type of data gathering in the name of scientific research? Whether we like it or not this type of activity influences our subconscious mind in a negative way.

Our job in society is to improve the physical and mental health of people. How can we create unity and oneness in the community if we emphasise ethnicity? Surely that can only come about by removing the barriers that separate us and not emphasising them.

As it is, there are parts in the world today where there is this horrible ethnic 'cleansing' going on. I do not think the medical profession should be involved in a process that makes people aware of their ethnicity and this data gathering, no matter how noble the purpose might be.

For the sake of our own and the nation's mental health, I humbly urge you to reconsider this issue and withdraw it from any accreditation requirements. I await your response."

I DON'T HAVE TIME FOR ALL THAT RELIGIOUS STUFF
BY DR PHILIP DUPRE

Maybe not, but there comes a time when we all face our own mortality and desperately want the truth. Jesus claimed to be the truth and he also claimed that we could only reach God through Him. Either he was absolutely right in this claim or He was the greatest deceiver in history, there is no middle ground. He was no just "A great Prophet". Incidently, Jesus had not time for "All that religious stuff" either and His outspoken attacks on religious leaders and their hypocrisy led to his death penality.

Jesus warned that if we reject Him and His claims then we will spend eternity in hell and the only means of avoiding hell is for each one of use to make a personal committment to Him and become "born again". No amount of good works is sufficient to avoid this penalty. Unbelievable? Too severe? Too rigid? Then check it out in God's workshop manual - The Bible. The rewards are hugh for obedience but so are the penalities fo apathy and rejecting God's conditions.

The Bible is the only Holy Book that validates its authority by containing multiple fulfilled prophecies and incredible encrypted codes that no other so-called "Holy Book" can lay claim too. Try searching "Bible Codes" on the internet.

If all this has offended you, I make no apology, it is intended as a wake-up call for your benefit. There is nothing more important in our lifetime than determining where we will spend eternity, so we had better get to the real truth before the door closes: "It is appointed for men once to die and then the judgement". No second changes.

THE IOMC – WORKING FOR ITS MEMBERS

Dr Ray Huntley from the Hub Medical Centre – Founder Member of the IOMC
A first for Australia – the Independently Owned Medical Centres lobby group has come to life to support hardworking G.P.'S and to assist in driving the profitability and efficiency of our respective medical practices.

HUB MEDICAL CENTRE
Lifelong Family Healthcare

TOGETHER WE CAN MAKE A DIFFERENCE

Dr Ray Huntley from the Hub Medical Centre – Founder Member of the IOMC

By joining the IOMC, doctors will have a unique opportunity to enter into a mutually beneficial partnership with a leading supplier of healthcare products. With sufficient members to make it a viable proposition, we will be in a position to negotiate and bulk buy medical products through a special Group Purchasing Program (GPP), currently proving to be very successful in the USA.

ADVANTAGES OF THE GPP INCLUDE:
✓**Significant savings by purchasing volume of medical supplies**
✓**Continuous supply of medical consumables will be ensured**
✓**Routine administrative and financial procedures will be minimised**
✓**Quality Assurance and control procedures will naturally improve**
✓**Wastages due to over stocking and non- essential items will be reduced.**

Right now the IOMC are also exploring further package deals with potential energy and communications suppliers for Members in the near future.

But to facilitate these benefits we need more doctors to become Members of the IOMC - it costs nothing to join, simply email admin@thehubmedicalcentre.net.au and look forward to increased savings.

Independently owned Medical Centres are fighting for survival, competing on a daily basis with the larger Corporates. The IOMC lobby group has been formed to give our hardworking doctors a fair go – a united voice to negotiate conditions, express opinions, create awareness and gain recognition from politicians and other influential parties where and when required.

We, in our key role as GP's and leaders in primary care will gain significant benefits by joining the IOMC.

Negotiations are currently underway with a leading provider of Healthcare products, the aim being to create a mutually beneficial partnership for IOMC Members by bulk buying products through an innovative new concept, the Group Purchasing Program (GPP).

The IOMC in Queensland is way ahead of the rest of Australia with introduction of the GPP which today is only practiced in the USA. Negotiations are underway for Members to gain exciting advantages by involvement with the GPP, which by ensuring a continuous supply of medical consumables will drive profitability and minimise routine and administrative procedures.
Quality Assurance as well as control procedures will naturally improve.

Wastage due to over stocking of non-essential items will be reduced as Members save by buying in bulk through the GPP.

But in order for IOMC to make this happen, we need more members and the more doctors who join, the more substantial the privileges and discounts will be for all of us.

The IOMC Group are currently also exploring further discounts with possible energy and communications deals for members in the near future. Again, we need a significant number of new members to gain negotiating power.

By becoming a member of the !OMC and uniting as a group, we can make a difference, not only to the bottom line but also to ongoing quality patient care of our respective practices.

Membership is free. If you haven't joined already, just email: **admin@thehubmedicalcentre.net.au**

Ray Huntley MBBS FRACGP

Lump sum super death benefits to adult children

Background

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

Paid directly from super fund

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

Paid via estate

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

Impact on Government entitlements

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

Other considerations

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

If you have a question please call Hayden White at Poole Group on 07 54379900.

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

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Australian Medical Association Limited
ABN 37 008 426 793

42 Macquarie Street, Barton ACT 2600: PO Box 6090, Kingston ACT 2604
Telephone: (02) 6270 5400 Facsimile (02) 6270 5499
Website : http://www.ama.com.au/

AMA

MEDIA ALERT - DOORSTOP

EVOLVING INTERNATIONAL HUMANITARIAN CRISIS FROM EBOLA OUTBREAK – GREATER AUSTRALIAN RESPONSE URGENTLY NEEDED

The AMA is calling on the Australian Government to provide greater immediate support to the World Health Organisation response to the Ebola outbreak emergency in West Africa.

AMA President, A/Prof Brian Owler, said today that the world is facing an evolving international humanitarian crisis, and Australia must provide urgent direct assistance.

A/Prof Owler will be available to comment on this and other health issues at 2.15pm today in the Senate Courtyard, Parliament House, Canberra.

A/Prof Owler Doorstop:

Time: 2.15pm
Date: Wednesday 10 September 2014
Venue: Senate Courtyard
Parliament House, Canberra

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10 September 2014

CONTACT: John Flannery 02 6270 5477 / 0419 494 761
Odette Visser 02 6270 5464 / 0427 209 753

Follow the AMA Media on Twitter: http://twitter.com/ama_media
Follow the AMA President on Twitter: http://twitter.com/amapresident

Dr Roderick Chua
MBBS (Syd) FRACP FCSANZ
Interventional Cardiologist
Heart Failure Specialist

Dear Colleague,

I am writing to let you know that I will be commencing additional consulting sessions at the

North Lakes Day Hospital
7 Endeavour Boulevard, North Lakes 4509

every **Thursday morning** from the
4th September 2014

I wish to thank all of you who have supported me so far in the last few years growing my practice.

I look forward to working with you and your practice. Thank you.

Kind regards

Contacts:
North Lakes Day Hospital Call 07 3861 5522
For direct contact my mobile is 0416 182 989

Queensland Cardiology
L3 Holy Spirit Northside Hospital
627 Rode Road, Chermside QLD 4032
Tel: 07 3861 5522

Northside Cardiology Services
Suite 4 George Street
Kippa-Ring QLD 4021
Tel: 07 3284 9164

North Lakes Day Hospital
7 Endeavour Boulevard
North Lakes QLD 4509
Tel: 07 3861 5522

Dear Colleagues,
By way of introduction to those of you whom I am yet to meet, I am an interventional cardiologist and heart failure specialist based at the Holy Spirit Northside Hospital working with Queensland Cardiology. I have admitting rights to the St Andrew's War Memorial Hospital.

I also have consulting sessions at Northside Cardiology Services, Kippa Ring. I was appointed as an interventional cardiology staff specialist at the Prince Charles in 2006. I perform a full range of coronary interventional procedures including primary infarct angioplasty.

I perform most of my coronary interventional work via radial artery access. I am a founding member of the Heart Valve Team and the Cardiac Medical Advisor of the Cardiac Rehabilitation program at the Holy Spirit Northside Hospital. I am fully trained as a Level A CT Coronary Angiogram specialist and I report CT coronary angiogram studies performed at the Queensland Diagnostic Imaging radiology department in the Holy Spirit Northside Hospital. I also perform both exercise and Dobutamine stress echoes regularly at Queensland Cardiology. I speak fluent Mandarin and Cantonese. I look forward to working with you and your practice.
Regards
Dr Roderick Chua.

A Mystery called Machu Picchu

By Cheryl Ryan

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

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

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

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

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

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

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

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

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

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

Sacred Valley of Cusco
Guides take you to Cusco and its popular sacred valley. Explore the Pisac and Moray ruins, to admire its cultural heritage. Now, we have access to Huchuy Qosco, a local village, which was previously bypassed for travelers. Enjoy this hidden gem and make the most of your Machu Picchu holidays!

www.123Travelconferences.com.au/

The Medical Journal of Australia • MJA
MEDIA RELEASE

VIGILANCE WILL KEEP AUSTRALIAN EBOLA RISK SMALL

THE risk of Ebola virus appearing in Australia remains small but continued vigilance and good infection control are critical to keeping it that way, according to a perspective published in the *Medical Journal of Australia*.

Dr Grant Hill-Cawthorne and coauthors from the Marie Bashir Institute for Infectious Diseases and Biosecurity at the University of Sydney wrote that the current Ebola outbreak in West Africa is the largest ever recorded, currently involving 3685 (probable, confirmed and suspected) cases and 1841 deaths (WHO update, 31 August).

"The species circulating in West Africa, *Zaire ebolavirus*, carries the highest mortality of the five known species", the authors wrote.

"Symptoms of Ebola virus disease (EVD) include fever, myalgia, severe diarrhoea and vomiting and, in some instances, internal and external haemorrhaging."

Beyond physical symptoms, however, Ebola also has social impacts, including stigmatisation of patients and food insecurity due to the isolation of quarantined villages, they wrote.

The risk to areas outside West Africa comes from spread via infected travellers, however, "Australia is well prepared for such a possibility", the authors wrote.

The federal Department of Health provides extensive guidance, and state departments have issued risk assessment guidelines and management algorithms.

"The diagnosis of EVD should be considered in at-risk patients (defined as those with fever and history of travel to an affected area within 21 days of onset) and expert medical advice sought", the authors wrote.

At-risk patients should be isolated and health care workers should use appropriate protective gear.

"The risk to Australia remains small; no cases of EVD have been documented here", they wrote. "However, continued vigilance for patients who fit the case definition, followed by their prompt isolation, is essential to prevent potential local transmission of the disease.

"While Ebola virus is a scary proposition, with good infection control and vigilant health authorities, outbreaks will not occur in this country.

"Instead, we need to focus our efforts on assisting the global response to the crisis in West Africa."

CONTACTS: Dr Grant Hill-Cawthorne 0487 603 463
Prof Tania Sorrell 0411 706 149

Australian Medical Association Limited
42 Macquarie Street, Barton ACT 2600:
PO Box 6090, Kingston ACT 2604
ABN 37 008 426 793
T: (02) 6270 5400 F (02) 6270 5499
Website : http://www.ama.com.au/

"INCENTIVE PAYMENTS NEEDED TO SUPPORT QUALITY AFTER HOURS PRIMARY CARE SERVICES"

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA is calling for the restoration of Practice Incentive Program (PIP) payments to general practices to support the provision of quality after hours primary care services in local communities.

The PIP call is a key plank of the AMA's submission to the Government's After Hours Primary Health Care Review (After Hours Review). AMA President, A/Prof Brian Owler, said today that the former Government cut direct PIP funding to general practices that provided after hours services, and shifted the funding to Medicare Locals, a move that was opposed by the AMA at the time. "Cutting the direct PIP payments to general practices was a big mistake," A/Prof Owler said.

"It created a clumsy new layer of bureaucracy with Medicare Locals responsible for channelling the funding to after hours service providers. "Many Medicare Locals failed to work with general practice to support high quality and accessible after hours services for patients. There was increased red tape and compliance costs for general practices, and there is no evidence of greater efficiencies "The new arrangements placed additional burdens on general practices that were operating successful after hours services, and demotivated GPs from providing after hours care."

A/Prof Owler said that GPs have traditionally provided after hours care to their own patients as part of a comprehensive approach to quality care, and this model should continue to be supported.

"There is no doubt that the best outcomes for patients are achieved where the GP has knowledge of the patient and access to their medical records," A/Prof Owler said.

"The restoration of PIP after hours incentives should address the needs of most parts of the country. Where there are identified gaps in after hours service provision, targeted funding should be made available to address them."

A/Prof Owler said that the AMA recognises the challenges faced in providing after hours services in many rural areas.

"Our submission highlights that models in these areas need to be innovative and flexible to ensure patient access to after hours services and an equitable spread of the after hours workload among providers."

The AMA Submission to the After Hours Primary Health Care Reviews is at: https://ama.com.au/submission-after-hours-primary-health-care-review

The AMA Position Statement on Out of Hours Primary Medical Care is at https://ama.com.au/positionstatement/out-hours-primary-medical-care-2004-revised-2011

10 September 2014

CONTACT:

John Flannery
02 6270 5477 / 0419 494 761

Odette Visser
02 6270 5464 / 0427 209 753

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription Benefits

Don't waste time! Join now!

Monthly: Newsletters, Topical Educational Meetings, 3 Course Cuisine,

CPD Points & Attendance Certificate Available

Rounded off with the End of Year Networking Meeting

Get your membership benefits! Socialise! Broaden your knowledge!

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.

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.

RDMA SUBSCRIPTION FORM – INTERNET PAYMENT PREFERRED

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

ABN 88 637 858 491

1. **One Member (July to June: $100; Oct.-June: $75; Jan-June: $50.00; April-June: $25.00)**
2. **Two Family Members ($25 Discount each) ($150 pro rata)** (Please supply details for both members)
3. **Doctors-in-training and retired doctors: FREE**

1. Dr. _____
(First Name) *(Surname)*

2. Dr. _____
(First Name) *(Surname)*

1. ***EMAIL ADDRESS***: _____@_____

2. ***EMAIL ADDRESS***: _____@_____

Practice Address: _____ Post Code: _____

Phone: _____ Fax: _____

CBA BANK DETAILS: **Redcliffe & District Local Medical Assoc Inc:BSB**: **064 122 Account**: **0090 2422**

METHODS OF PAYMENT:

1. **PREFERRED INTERNET BANKING**
2. **PAYMENT BY DEPOSIT SLIP**: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. **ENCLOSED PAYMENT:** (Member Subscription Form on website, type directly into it and email)
   i) **Complete form & return:**
      - **c/-QML or Redcliffe & District Medical Assoc Inc. P O Box 223 Redcliffe 4020**
   ii) **Or by email to GJS2@Narangba-Medical.com.au**

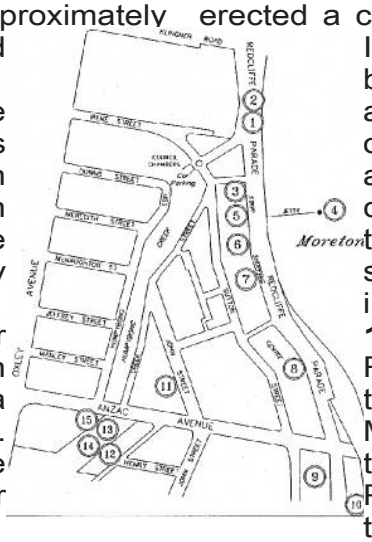
Where We Work And Live

The Henry Miller Trail Self Guided Walk. Continued.

3 COMMISSARIAT STORE At September 1824, Store keeper/surgeon Walter Scott had the Commissariat Store built approximately where the National Bank is situated today.

4 REDCLIFFE JETTY The first jetty was built in 1885 and was replaced by the second jetty, which was built 20 metres to the north in 1922. This site is probably where the convicts landed from the Amity to establish the first settlement.

5 COMINO'S ARCADE Arthur Comino arrived in Redcliffe in 1922 he bought the Moreton Vista boarding house and adjacent shops. Rebuilding after a fire the first three storey building in Redcliffe – later known as Comino's building



6 PIER PICTURE THEATRE The open air Redcliffe Picture Palace was built in 1917 opposite the Redcliffe Jetty. The Beedham family purchased it in the early 1920s. In 1926 they bought a larger block nearby and built the Pier Theatre. On 15 March 1943, after a free evening for servicemen on 14th, the theatre was destroyed by fire. By December 1943 a new theatre was built and reopened. 1969 saw the end of the old theatre when the stalls section was demolished it began a new life as a retail store.

7 KOOPA DECK The Koopa Deck was named in honour of SS Koopa, which holds a nostalgic place in the city's maritime history. In 1911, it arrived from Leith, Scotland and was used as an excursion boat from Brisbane to Redcliffe and Bribie Island. Koopa was certified to carry 1153 passengers and plied its trade until 1942 when it was requisitioned by the Royal Australian Navy and commissioned in September 1942.

8 AMBASSADOR HOTEL In 1881 the first hotel in the Redcliffe CBD was built by Patrick O'Leary and originally named the Redcliffe Hotel. It stands on the original site of the kitchen and barracks of the 1824 settlement. In 1970 council employees while building the car park, found a square wooden structure believed to be a convict built well. An air raid shelter from WW11 forms part of the Hotel's bottle shop.

9 SEABRAE HOTEL John Harrop Henzell bought land at Redcliffe Point in 1882 and erected a cottage, which he named Seabrae. In 1909 Seabrae was turned into a boarding house. Further wings were added in 1926 and 1929. In 1934 the original Seabrae was demolished and a new two-storey building was constructed. The Australian Army took over the premises in 1942 and sublet the building to the US Navy in 1943.

10 JOHN OXLEY MEMORIAL Research since 1932 has revealed that some incorrect inscriptions Matthew Flinders did not appear to land near what we call Redcliffe Point. On 17 July 1799 he sailed past this point in the Norfolk and landed near Woody Point and Clontarf Point. He gave the name Redcliffe Point to the southern end of the Redcliffe Peninsula. On 5 December 1823 John Oxley spent the afternoon exploring the Peninsula not leaving a record of where he landed.

11 COMMANDANT'S HOUSE The Commandant's house was designed in Sydney of timber, for transportation to Red Cliff Point and brought up in a frame on the Amity. When the settlement moved to Brisbane, it was dismantled and re-erected with brick chimneys on the site of the Government Printing Office in William Street.

12 BRICK KILN Clay at Humpybong Creek south of the bridge where a brick kiln was established on this site in 1824. Making the first bricks from here in Queensland.

13 FLINDERS' MEMORIAL The Flinders' Memorial commemorates the landing and naming of Redcliffe by Matthew Finders 1799.

14 WEIR A log weir was built across Humpybong Creek by convicts in 1824. The concrete weir was constructed in the 20th Century.

15 REDCLIFFE MUSEUM The Redcliffe Museum built within the former Sacred Heart Catholic Church run by the Redcliffe City Council and celebrates Redcliffe's history.

The Henry Miller Self Guided Walk

http://www.redcliffehistoricalsociety.com/id13.html