RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
FEBRUARY 2015

Facts You Didn't Know About Valentine's Day

See Where We Work & Live & RDMA's February Invitation on page 20

President's Report Dr Kimberley Bondeson

Welcome to 2015 and so far, what an interesting year. A change of state government, and many distressed patients and General Practitioners, over the governments proposed enforced GP co-payment. What does it mean for Medicare? Is the co-payment and medicare indexation freeze scrapped? We still do not have a confirmed outcome. It has been reported that the Prime Minister, Tony Abbott, has "given ground on contentious policies", which some of his party took to mean that the $5 rebate cut and indexation freeze adopted in December would be scrapped. However, it turns out that Mr Abbott has only pledged to "consult" on the policy.

This resulted in myself, as President of the Redcliffe and District Local Medical Association, receiving a phone call from the Hon Teresa Cambaro, MP's office, requesting a meeting with RDMA. The outcome was a joint meeting, with representatives of RDMA Committee and the NLMA committee with the Federal Health Minister, Susan Ley, the Federal Member for Brisbane, Teresa Gambaro and Member for Petrie, Luke Howarth.

Also representing RDMA and NLMA were Dr Shaun Rudd, and Dr Steve Hambleton. All GP's, with the same message. Dr Maximum Wilson, Physician, a long term RDMA member was also present. Many thanks to all who attended. I was proud to be part of the team. A summary of the meeting is in the following letter.

The Honourable Sussan Ley **6th February 2015**
Minister for Health

Dear Minister,
It was a pleasure to meet with you last night at Luke Howarth's office to discuss GP issues from the perspective of the grassroots practitioners as represented by the Redcliffe and Districts Medical Association and the Brisbane North Local Medical Association.

We remind you that we are closer to the workplace than the AMA or AMA Queensland or RACGP, and our viewpoints may differ a little from the positions of those organisations.

We prepared a list of potential discussion points, most of which were not raised during the meeting. However, we commend that list for your consideration, because the list was compiled after wide discussion with our GP colleagues, and reflect the sentiment in our community. We recognize that there are some issues of concern to GP's that, important as they are to us, will not be achieved in the current political and economic environment. The most prominent of these is a desire for indexation of Medicare rebates. We reflected the widespread concern among GP's that they are undervalued and constantly battered by politicians and the media.

(a) Illustrative of this, we prepared a briefing document on GP-referred MRI's, although that topic was not specifically raised, and its potential for some savings in health costs.
(b) We also referred to a widely held view that EPC items, in some cases, are of limited value, and we see better health outcomes arising if GP's had more liberal opportunity to refer patients to allied health personnel.
(c) We reiterated that general practice, in conjunction with universal health insurance provided by Medicare, is responsible for optimal health outcomes.
(d) We repeated that general practitioners know their patients best, and offer continuity of care with advantages in economy and safety.
(e) We referred to past

Cont: Page 3

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 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

Meeting Dates to be Confirmed Feb 2015

Next	Tuesday	February 24th
	Wednesday	March 25th
	Tuesday	April 28th
	Wednesday	May 27th
	Tuesday	June 30th
	Tuesday	July 28th
	Wednesday	August 26th AGM:
	Tuesday	September 15th
	Wednesday	October 28th
	NETWORKING:	
	Friday	November 27th or December 4th TBC

RDMA NEWSLETTER DEADLINE

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

NLMA 2015 Bi-MEETING DATE CLAIMER:

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

2015 Date Claimers: TBC Early 2015

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

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RDMA PRESIDENT REPORT
Dr Kimberley Bondeson Continued from Front Page:

government policies that were ill-conceived and doomed to failure because the government of the day failed to consult with practitioners. Most prominent of these is the 4-year-old well child check.

We had some discussion around the future shape of primary care and how this might fit with the government's need to manage the expanding health budget and maintain sustainable quality primary care.
(a) Specifically, we presented a briefing document proposing closer consideration of GP-determined co-payments. We suggested that this might be a least-bad alternative palatable to the government, the medical profession, and the people of Australia.
(b) We had some discussion around changing practice models to utilize GP skills more effectively with particular reference to the possible use of health assistants or nurse practitioners, in some instances, in a truly collaborative primary care team.
(c) We also referred to the hoped-for war against red tape. We prepared a briefing document on what we see as the easiest red tape target, curtailment or abolition of the authority prescription system.

In common with the government, we are concerned about the rising cost of health, both in absolute terms and as a percentage of GDP. We believe that most of the topics that we have discussed have potential to reduce health expenditure while maintaining the high quality of care enjoyed by most Australians.

I commend these discussion points for your continuing consideration, and thank you for taking the time and trouble to listen to our viewpoints at first hand.

Yours respectfully,

Dr Kimberley Bondeson
B.Sc(Hons). MBBS, FRACGP, DAME.
President
Redcliffe and District Local Medical Association.

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AUSTRALIAN MEDICAL ASSOCIATION QLD
PRESIDENT
Dr Shaun Rudd

MEMBERS' UPDATE

Dear Members,

Though we are well into the year, as this is our first column of 2015, I would like to take the opportunity to wish you all a happy new year.

It has become clear this will be another big year for the medical profession. As many of us were returning from holidays, the Government was planning to implement a $20 MBS rebate cut to short consultations that would have come into effect in mid-January.

This measure would have been undoubtedly damaging to the viability of General Practice and stopping its implementation quickly became AMA's first priority as we advocated for the Government to stop the introduction of this cut.

This advocacy work was successful and we were relieved to hear of the cut being abandoned.

This was a big victory for GPs and their patients across the county and we were glad to see the Government is committed to consultation.

While this was a major achievement for AMA and a big win for GPs and patients across Australia, our advocacy work is not complete. The Government is still planning to implement the $5 rebate cut to most consultations from 1 July.

By the time you get this letter, we will have already hosted our Queensland GP Forum.

Feedback gathered from these forums, which are being held across the country, will serve as a blueprint for our consultation with Government going forward.

Make sure to keep an eye on www.ama.com.au and www.amaq.com.au for updates on our advocacy work.

While the co-payment has been a national issue, in Queensland, we have also been focused on the election. In the lead-up to the election, we worked with all parties to advocate on behalf of doctors and patients.

We called for measures that address the growing obesity epidemic and alcohol related harm, improving end-of-life care for Queenslanders and upgrading IT systems in hospitals to ensure they operate at maximum efficiency.

These platforms are integral to improving the quality of care in Queensland and achieving better health outcomes for patients.

We will continue to advocate for these Health Measures and I look forward to working with the Health Minister, whoever that may be, to continuously improve the state of healthcare in Queensland.

I would also like to take a moment to remind you that AMA Queensland renewals were due at the end of 2014.

If you haven't yet renewed, please give the AMA Queensland team a call on 07 3872 2222 as soon as possible to ensure you keep receiving your member benefits.

Changes to healthcare in Queensland show no sign of slowing down and your membership is more important than ever.

Sincerely,
Dr Shaun Rudd,
AMA Queensland President

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

2014 Reflections, New Health Minister & Footnote on Politics

Christmas is a religious festival. In an increasingly secular world where religion has less relevance, Christmas is a time for peace, happiness and families.

Christmas 2014 in Australia challenged that tradition. In the fortnight before Christmas, we saw a hostage situation in Sydney, and a mass murder of innocent children in Cairns.

My theme in this column is that, for both those tragedies, somebody could have seen it coming.

The Sydney hostage scene re-ignited all the xenophobic anti-Muslim sentiment. It is a matter of semantics whether it was a "terrorist" act, depending on how you want to interpret the Muslim inspiration for a sole madman's acts. What is not a matter of semantics is that fact that at least three groups of observers should have been able to predict that the sole madman could and would have done something of this nature. Firstly, the Muslim community has not been very visible, either in Australia or abroad, at identifying its own members who were going to cause trouble. Secondly, the judicial system failed Australia by allowing a man with a disturbed history to walk the streets unhindered. Thirdly, surely there were health professionals who, during the decade of his now-public personal history, must have seen enough of his psychological disturbance to raise an alarm.

The Cairns massacre prompted another series of tirades against our indigenous population and drug-users. Let's be very clear – this is NOT an Islander (or aboriginal) way of behaviour. Let us be equally clear – irrational and psychotic behaviour IS an outcome of use of the feral amphetamines now readily available on Australian streets. But my experience (both from indigenous health work and drug abuse practice) is that our indigenous population does not regularly use methamphetamine as their drug of choice – "gunga" is cannabis and is cheaper and more readily available, and alcohol is ubiquitous. Cannabis promotes lethargic behaviour, and alcohol fuels violence, but neither is commonly associated with wildly disturbed behaviour.

But I must return to my main theme. Although the lady at the centre of the criminal enquiry was not well known to health or forensic authorities, again there must have been enough signs to health workers that this lady was troubled.

In the cases of the Sydney hostage scene and the Cairns massacre, it does not help to point fingers at health workers or social workers who saw the signs but failed to raise the alarms. What does help is to remind health workers everywhere to be aware, "alert but not alarmed", that we are going to be among the first to identify that our patients are in trouble. Our duty to our patient is to ensure that we are alert to their troubles and that we are prepared to offer our opinion and open doors to treatment where possible. We also have a duty, often a conflicting duty, to the wider community, to protect those who might become victims of our disturbed patients.

It takes little imagination to widen the scope of our duty to protect the public. I could accuse politicians and lawyers of having little imagination, but I hope that we do not see a knee-jerk reaction of expanding the mandatory reporting laws. There are increasing numbers of laws that dictate mandatory reporting, especially of suspected abuse of the vulnerable, the very young and the very old. GP's are often reluctant to report our patients as impaired drivers, but that is our moral and legal duty.

The message should be loud and clear for the medical community. We see the signs of illness in our patients and we act to help them. The two pre-Christmas tragedies remind us that sometimes our role is wider than the comfortable armchair role that we happily accept.

NEW FEDERAL HEALTH MINISTER.
The holiday season also brought a Cabinet re-shuffle. We have to ask who is this Sussan Ley? And are we better off with her than we were with Peter Dutton?

Sussan Ley has an interesting personal history. She is not home-grown, but was born in Nigeria, coming to Oz when she was **Cont: Page 6**

AMAQ BRANCH COUNCILLOR NORTH COAST REPORT
Dr Wayne Herdy Continued from Page 5:

13. Her education was centred on accountancy and economics – hopefully not a warning that she is a blind bean-counter. Her post-education history is much more fascinating, and gives us hope that she is actually a Minister with some humanity and imagination. In her younger days, she was something of a wild lass. She was a punk rocker and wore a chain with a razor-blade hanging from one ear to her nose piercing. She was married to an itinerant shearer living in a caravan as they wandered the countryside. She met him while she was working as a pilot doing aerial mustering. To pay for the flying lessons, she worked extra jobs waitressing and cleaning department stores. She still holds a commercial pilot's licence, and wanted to fly the big jets but never got selected. None of this sounds like the start of a career as a bureaucrat. While her father (a farmer who graduated to the Australian Federal Police) might not have approved of her early days, he must be pretty happy with the way she is heading since entering politics.

We will watch and see, but I suspect that we finally have a Health Minister who actually understands what real life is all about. My gut feeling is that, like her ever-suffering Dad, we are going to be pretty happy with what we are seeing.

FOOTNOTE ON POLITICS.
What a wild beginning to the politics of 2015 this has been.

QUEENSLAND ELECTION.
While the polls predicted that the voters of Queensland would punish the Newman government, nobody predicted just how punishing the result would be. The final numbers are still unknown as I write, but one thing is clear – Queensland will have a new government. We will have a new Health minister, and likely an individual who has no ministerial experience. The new government will have a very different complexion from any we have seen before. Right now, I would not dare speculate on what sort of reception medical lobbyists will receive in the office of the new Minister. What I will speculate on is that we are going to be on a steep teaching curve taking an inexperienced parliament through the process of listening to our message (yes, I meant "teaching", not the usual cliché "learning curve" – we will be the experienced players in the negotiating field, and I doubt that the pollies will be in any hurry to admit that).

BACKFLIP ACROBATICS.
Only a few days before Australia was ready for a major weakening of the basic structure of Medicare, the government announced that they were abandoning their plan to curtail the breadth of GP bulk-billing. The proposed $20 cut to rebates for shorter consultations has been shelved (but possibly not binned). This was almost certainly because the government knew that the proposal would be defeated in the Senate. While we like to flatter ourselves that medical lobbying persuaded the government to see our point of view, our influence was probably only a small influence on the final decision. It was embarrassing to abandon the proposal only days before its implementation. It would have been more embarrassing to have the "reform" defeated by an uncooperative Senate weeks or months later, and work out how to refund to doctors and/or patients the wrongly calculated rebates.

But the Medicare reform proposals are not dead and buried. Like Work Choices, they are being remodelled and will surface at another time and place under another name. Don't lose sight of the related proposals to reduce the Medicare rebate and to freeze rebates for five years. There will be copious underground negotiations and discussions before we see the next head of this Hydra ready to strike.

CANBERRA UNDER SEIGE.
On the federal playing ground, the Abbott leadership debate is increasingly unsettling. After the Queensland election and the Sir Prince Philip debate, the PM's position appears very uncertain. There is a widely held view that he has not listened to the people, and would not have understood even if he had listened. The PM has delivered a speech at the Press Club on 2nd February, in which he departed from his customary line and admitted fault, laced with promises to listen and consult. Tony Abbott has been forced to eat humble pie and abandon his signature policy of paid parental leave. It did not go un-noticed that there was no mention of health economics in that Press Club speech. Despite that speech, Australian business seems to be abandoning the coalition. My crystal ball sees a rapid downhill slide from here for the Liberal leadership. If my crystal ball is right, we might be seeing a new Federal leader. If this is as inevitable as it seems today, the big question for us is whether the power shuffle will involve a radical review of the Cabinet. Will we have a new Health Minister in Canberra, or will Sussan Ley survive the seismic event?

Dr Wayne Herdy, AMAQ Branch Councillor

MORETON BAY RADIOLOGY

Calcaneo navicular coalition

Findings

XRAY- The anterior process of the calcaneus is elongated and sclerotic (white arrow). This elongation is termed the "anteater" sign; confirmation is made on oblique radiograph of the foot. The anterior process of calcaneum is normal on the left side.
MR- A widened and elongated anterior process of the calcaneus is seen extending to its abnormal union with the navicular. The calcaneonavicular joint is broadened, irregular and sclerotic.

Diagnosis

Findings in keeping with calcaneonavicular coalition.

Discussion

Calcaneonavicular coalition is one the two most common subtypes of tarsal coalition, the other being a talocalcaneal coalition. As with any coalition may be osseous (synostosis), cartilaginous (synchondrosis) or fibrous (syndesmosis).

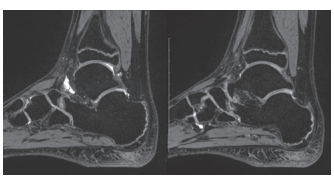
Radiographic features

This type of coalition is more easily diagnosed on plain film than a talocalcaneal coalition.

Plain film

Oblique view

- best at depicting calcaneonavicular coalition directly as a calcaneonavicular bar



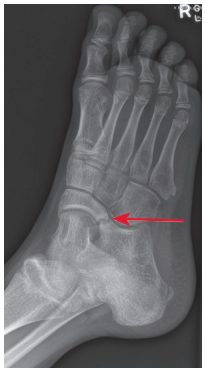
AP view

- may also directly show coalition
- indirect signs include
- broad proximal surface of navicular - broader than the articulating talar head
- lateral tapering of navicular

Lateral view

Indirect signs include:

- anteater sign: elongated anterior process of calcaneus
- reverse anteater sign: elongated lateral navicular
- talar beak
- short talar neck



CT

CT can be used to confirm the diagnosis where this was equivocal or not seen on plain films. It may allow be used for surgical planning

MRI

MRI is probably more helpful in assessing and characterising cartilaginous and fibrous coalition and allows assessment of associated bone and soft tissue oedema.

Treatment and prognosis

As with any tarsal coalition, non-operative management may allow some improvement in symptoms initially, but they usually return. Surgical treatment with excision of the coalition is usually required.

REFERENCES
http://radiopaedia.org/articles/persistent-sciatic-artery

AMAQ BRANCH COUNCILLOR REPORT
GREATER BRISBANE AREA
Dr KIMBERLEY BONDESON

Consultantion Process With Federal Health Minister

This is the speech given by Teresa Gambaro, MP on 11th February, 2015 to Parliament.

In this speech, she discusses Medicare, and the difficulties that the government are facing in terms of its funding, and sustainability to enable quality healthcare.

She acknowledges the doctors from the Northside Local Medical Association, and the Redcliffe and District Local Medical Association, who were and are continuing to be part of the consultation process with Minister Sussan Ley.

HOUSE OF REPRESENTATIVES
PROOF ADJOURNMENT
Health SPEECH
Wednesday, 11 February 2015

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

Wednesday, 11 February 2015
HOUSE OF REPRESENTATIVES SPEECH

Ms GAMBARO (Brisbane) (19:56): Australia's healthcare system is at a cross road. The system we set up in July 1975 when Medibank officially commenced, almost 40 years ago, no longer meets our needs. When we consider that Australia's population in 1975 was 13.9 million as opposed to the 23 7 million we are today then this should be no surprise.

Treasury's first Intergenerational r eport in 2007 forecast that the Australian government's expenditure on health was projected to increase as a proportion of GDP from 3.5 per cent in 2006-07 to 7.3 per cent in 2046-47, with about a quarter of these increased costs coming from an ageing population. Treasury's 2010 Intergenerational r eport identifies a number of drivers of the expected rise to extend beyond just an ageing population to include population growth, demographic pressures, demand for higher standards of care and rapid technological innovation. Another thing that should not surprise us, and it is something for which we can be thankful is that medical knowledge, technologies and treatments have not remained static; they have changed and evolved and will hopefully continue to evolve into the future for our collective benefit.

All of this change and growing demand, however, creates stresses that the existing structure of Medicare cannot handle, and ultimately this is not a sustainable dynamic. The gravity of this situation has been well and truly recognised by the new Minister for Health, the Hon. Sussan Ley, and in her statement on 16 January this year she pointed out the following inconvenient and uncomfortable truth about Medicare, and I quote:

AMAQ BRANCH COUNCILLOR REPORT GREATER BRISBANE AREA

Dr Kimberley Bondeson Continued from Page 8:

It's not sustainable now. The Medicare levy raises $10 billion approximately at the moment and the cost of Medicare is $20 billion. So the Medicare levy is hopelessly inadequate in funding Medicare, but the scary thing is in 10 years' time, the cost of Medicare will be $34 billion and while the Medicare levy will be a bit more, it will be nowhere near that figure. So everyone recognises we need to make Medicare sustainable and we can't have it collapse under its own weight.

If we want Australians to have access to the best quality healthcare in the world, which is what our citizens have come to expect—and which they rightly should have—then Medicare requires structural reform.

In my view, this is the one of the greatest public policy challenges confronting our country right now. We need to properly acknowledge it and move collectively and cooperatively to address it. Failure to do so will fundamentally change Australians' quality of life for the worse. A sustainable future for Medicare cannot be achieved through a process of finger-pointing and recrimination. Demonising doctors, engaging in cheap political point-scoring or going for a quick fix, dare I say it—a bandaid—will not get the job done. If we are to assume that everyone, the medical profession, politicians of all persuasions and patients, all wants the same thing—that is, the best possible health outcomes for all Australians now and into the future—then we must all be engaged in creating the solution. Good policy does not happen in a vacuum. It will not magically appear out of thin air. And, while the logic of this statement might seem self-evident and obvious, the highly regrettable combative nature of our political environment can make the achievement of this goal seemingly impossible.

My challenge to everyone in this place is to put aside petty political divisions and support the Medicare consultation process Minister Ley is currently undertaking around the country. If ever there was a public policy issue demanding bipartisan support then this is it. I also challenge the medical profession to be part of this process. I know the minister wants to hear from you—and, in my electorate of Brisbane, I want to hear from you. In this regard I want to thank those members of the medical profession who only last week made time to meet with the minister and I as well with my parliamentary colleagues the member for Longman and the member for Petrie. Your insights were invaluable. I want to specifically acknowledge the doctors from the Northside Local Medical Association; Abbe Anderson and staff from the Medicare Local Metro North Brisbane; the Royal Australian College of General Practitioners; Dr Shaun Rudd, President of AMA Queensland; and the Redcliffe and District Local Medical Association.

The challenge of meeting the future healthcare needs of Australians has not crept up on us in the dark. We cannot and must not fail in our responsibility to meet it.

House adjourned at 20:02
CHAMBER

COMPUTERS & GADGETS

Email: apndx@hotmail.com.
with Doctor Daniel Mehanna

"The King Still Reigns"

Although Apple's reign on the smartphone market has undeniably taken a substantial hit in recent years due to the Android onslaught, one area where Apple remains dominant is the tablet market.

There, Apple is the undisputed king.

Despite numerous salvos fired from companies such as Samsung, HTC and the like, the Apple iPad remains supreme. With a near perfect blend of slick software and stylish hardware working in perfect harmony (partly because Apple designs both) there just has not been a reason for consumers to go with Android.

It is with this in mind that the Nexus 9 tablet was released late last year. For those who don't know, the Nexus line of phones and tablets are something special. Every year Google partners with a manufacturer and co-designs and manufactures a phone or tablet. The product is supposed to showcase what is possible using the latest Android operating system and latest hardware and to encourage other manufactures to strive to improve their products. Suffice to say, there is a lot of hype and expectation from the Android community every year awaiting each Nexus release.

Having an old and slow Acer A500 tablet that was well and truly due for retirement, I took the opportunity to upgrade to the Nexus 9.

The Nexus 9 is basically an 8.9 inch tablet manufactured by HTC and co-developed with Google. In looks it is reminiscent of a large Nexus 5 smartphone. Inside, it houses the latest NVidia 64-bit processor, a decent 2GB of RAM, dual front-facing speakers and a battery with capacity to keep it all up and running for a little over nine hours. So far so good. Significantly, however, (as with all other Nexus devices) there is no way to insert a micro-USB to increase storage capacity.

The Nexus 9 weighs 425 grams which is heavy for its size. It measures out as 228mm tall, 154mm wide, with a 7.95mm depth, which is thicker than both the new iPad and Nexus 7. Inexplicably, it suffers from several obvious manufacturing flaws. One is that the volume and power button on the side of the tablet is almost flush with the case. The button is very difficult to palpate, making the tablet cumbersome to use. The second is the amount of "bleeding" around the edges of the otherwise quite capable screen. This is seen as a white area at the edge of the screen, which for a $600 product in plainly substandard. The third is that the back of the tablet actually "gives" a few millimetres and creeks. All of these defects are not only quite obvious but surprising from HTC (a manufacturer generally known for the quality of their hardware).

On the plus side, however, the screen is otherwise good, the sound - courtesy of two front facing speakers - is clear and the Nexus 9 showcases Lollipop well. Having said that, it is not, admittedly, as smooth an operating system as Apple's, exhibiting the occasional slow down and glitch. Hopefully this will be remedied in the next update, version 5.1 to be released this month.

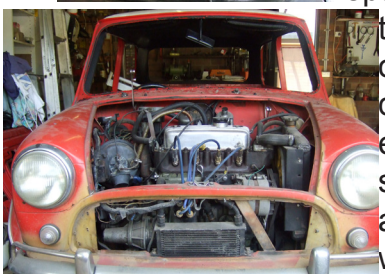
So don't get me wrong. The Nexus 9 is not a bad tablet by any means. It just does not have the polish and finesse and finish of Apple's iPad. We'll just have to wait until next year...

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #116
Safe motoring,
doctorclivefraser@hotmail.com.

"Mini Cooper S Restoration" (Part 1)

By the time most of us reach 45 years of age we're definitely on the downhill run. Hypertension, glucose intolerance and worn joints are all starting to take their toll. On average we can expect maybe another 40 years and many visits to medical providers to keep us going. Very few cars will ever reach the age of 45 and those that do are like the centenarians of the auto world. By that age there are definitely going to be a few reliability issues, but some owners love their cars so much that they will not spare a cent and embark on a full restoration.



I have a friend with a 1970 Mini Cooper S who spent many years, countless hours and an un-publishable amount of money restoring his car back to its original showroom condition. He has given me some very good advice on how to approach such a task. For starters he bought the car with the intention of restoring it. That is, he chose a car that was worth spending the time and effort on, not just a car that was old and still in one piece.

The Mini will always be a classic, but he meticulously ensured that his car was a real Mini Cooper S and not a Mini Deluxe that had been doctored up with an "S" badge. My friend knew that the car was mostly complete and that the missing parts would be eventually locatable. The car had been fitted with some after-market options by a previous owner, including mags and a sports steering wheel. All of this would have to go as in this restoration the car would be returned to the exact way it was when it left the factory. The Mini was tired-looking and the motor ran roughly. Its previous owner said, "It just needs a tune-up", but the truth was that the cylinder-head was cracked. After so many decades that wasn't a problem as everything was going to be completely re-built anyway.

The Mini was completely stripped down to its components and many bits were stored in the rafters and some parts even under the bed (eg the windscreen). The body was sand-blasted back to bare metal and like an archaeological dig this exposed quite a few issues, namely rust, dents and previous poor quality accident repairs. But worst of all, someone in the past had tried to strip the paint off with an angle grinder leaving deep score-marks in the metal everywhere. These marks would show up through the new paint job and would need to be carefully filled with priming paint. Fortunately, Minis were made of thick steel which was strong enough that an owner could stand on the roof. I wouldn't try this in a modern car.

Unlike modern cars Mini body panels were lapped together outwardly with the seam covered by a U-shaped bead. Water invariably sat in this space and there were plenty of places where rust needed to be excised. The Mini body shell could be lifted by three strong men, but to make the under-body repairs easier my friend skewered the car on a piece of wood through the boot and a hole in the firewall where the speedo sat. The wheel well and battery box were too rusted to preserve, but they were simple enough to re-fabricate. With the body-work restored and with the help of a good mate the car was re-painted to its original red colour and for the first time it was possible to see that this job might just end up being completed, one day. To be continued.

Safe Motoring Doctor Clive Fraser

Medical Marijuana. An Opinion Piece

By Dr Wayne Herdy

I have worked in the drug and alcohol field for two decades and cannot help but disclose that I have a strong bias against the proposals to use marijuana for therapeutic purposes. My readers will identify that, despite my declared negative position, I remain ambivalent. I make no apology, because I am far from alone in my ambivalence. Australian jurisdictions are adopting increasingly soft approaches to marijuana. But the Federal government recently blocked a proposal to grow legal marijuana on Norfolk Island (a tiny economy struggling to survive and desperate for a new industry).

My position has changed in the latter decade. I used to say that marijuana was relatively harmless, that its greatest social harm was its undeniable role as a gateway drug encouraging progression on to more damaging drugs, that it had low addictive potential, and that my greatest concern was that any user of marijuana became an outlaw by definition and had to move in criminal circles to access and use it. My view changed with the dominant use of hydroponic marijuana.
The illegal growers of marijuana seem to have changed the plant. "Hydro" has much higher levels of cannabinoids than "bush" marijuana, and seems to have higher proportions of those cannabinoids associated with cell toxicity and mood changes. Modern street marijuana appears to have bred out much of the cannabidiol, the molecule for which there is strongest evidence for real medical benefit.

The proponents of medical marijuana often come from a subculture where illicit street drugs are part of normal life. It is very hard for them to rebut the presumption that they are trying to use pseudo-science and emotive argument to justify legalized, and even subsidized, access to a substance that is presently denied to them by its illegal status. Possibly 30% of adults have tried marijuana, and that creates a significant public voice that is reluctant to oppose medical marijuana, even if they do not actively support it.

There is a growing list of respectable medical organizations and local legislatures that support the use of medical marijuana. The more conservative legitimate medical organizations are still taking refuge in the policy that there is room for more research to be done before they can support medical marijuana. This is one of the fastest-growing fields of pharmacological research. Maybe it is remarkable that, so far, little in the way of real outcomes has emerged despite the mass of effort of enquiry.

Recently, the Public Health Association of Australia endorsed medical marijuana. But they seriously compromised their scientific and professional credibility when they added: "Even if it's just a placebo effect, why would you deny it to somebody who is dying?" This might be a reasonable argument in some individual cases, but surely the wider public health dangers of endorsing such a product outweigh the small potential benefits to a small number of individuals.

Medical marijuana has also seduced genuine pain sufferers who are beguiled by the claims of the less respectable proponents. If medical science has failed to control your symptoms adequately, you will be naturally curious about those who offer relief where conventional medicine fails. Here lies a tragedy – that the sick and dying add their voices to support unproven remedies.

I use the term "pseudo-science" a little unjustly. There is undoubtedly some science to suggest or even prove that marijuana has some (but not all) of the benefits that its supporters claim. But most of the science is not of the first quality. Many of the studies are tainted by bias, and none approach the gold standards and large numbers that we now expect of studies proving the benefits of new pharmaceuticals. They tend to downplay the lack of good evidence of safety, prominently neglecting the science that proves irreversible genetic damage. Real science in this field is difficult. Apart from the resistance against approving research into a controversial illegal drug, the chemistry of cannabis is incredibly complex. The complexity of the chemical family is in itself a reason why research must proceed slowly and carefully.

At the end of the day, the proven benefits of marijuana are mostly based on management of nausea and anorexia, especially in cancer treatments. Without good head-to-head studies, I still adhere to my view that we already have access to legal and proven pharmaceuticals that are at least as effective, and I cannot see that the promoters of medical marijuana have proven a case that their product is superior to the existing drugs, or safer.

Some of the myriad claimed therapeutic effects of marijuana are quite dubious and contradictory. Cannabis has long been recognized as the great unmasker of schizophrenia, and a well-documented side effect is delusional paranoia. It would be more than surprising if it were actually proven to have anti-psychotic benefits, but that is what cannabidiol appears to do. Despite its well-known side effect as an appetite stimulant, it has been ineffective in treating anorexia nervosa. Despite THC causing cognitive impairment, cannabis is claimed to have anti-dementia properties. Marijuana does affect mood (mediated by only one of the 120-odd molecules

in the family, and then only when the molecule is altered by heating), but how much does it really effect the immune system or cancer growth or bone metabolism?

One of the mysteries yet to be clarified is why evolution gave us marijuana receptors and endocannabinoids. If they are part of our DNA, why is it so? That is what the research has yet to tell us. Right now, my gut feeling is that the evolutionary advantage was related to appetite stimulation and fat metabolism. Marijuana causes the munchies, and drug trials are investigating a marijuana receptor blocker for use as an appetite suppressant. But are there other biological advantages? We just don't know. And remember that not everything in our genes is good – we are all programmed for cell apotosis which limits our life expectancy, and some of us are programmed to develop lethal diseases.

The inevitable argument against medical marijuana is that there is an unmeasurable potential for the legal drug to be diverted to personal recreational use. The best study that I have seen on this hazard concludes that consumers of medical cannabis occupy a continuum between legitimate medical use and recreational use. I interpret this to place cannabis near the category of controversial drugs like the sympathetic amines (both the respiratory medications and the appetite suppressants), far more worrying than the recent experience with oxycodone and alprazolam, and quite some distance away from our experience with other proven pharmacological agents. And here is the strongest source of my personal bias. My own experience is that all of the patients who have approached me requesting my support for their personal use of medical marijuana to manage their supposed symptoms are patients who are deep into the drug subculture and have an established history of many years' use of illicit marijuana long before they decided to seek professional support for their continuing use. I manage chronic pain patients, probably more than the typical GP, and I cannot recall having received an enquiry about medical marijuana from a single patient who has a demonstrable and genuine physical source of their symptoms.

While I continue to stand against the too-early use of medical marijuana, I regret that I have to fall back on the cop-out catchcall that there must be more research done. When there is good research that tells us why we have marijuana receptors and what they really do, maybe another decade from now I might have to change my mind again. By then I might even be using it myself to ward off my impending dementia.

Poole Group
ACCOUNTANTS & INVESTMENT ADVISERS

Increasing disability insurance to allow for tax

Strategy for individuals under age 60

One of the criticisms surrounding insurance through super is that the benefit paid out of super may be subject to tax, whereas the benefit outside super will be tax-free.

A lump sum disability benefit is taxed as a normal super lump sum i.e. it is paid tax-free from age 60, but may be taxable under age 60. In the event that tax will be payable on a disability super lump sum, the insured amount may be grossed up to offset the tax. In most cases, the real cost for the larger sum insured still works out cheaper inside super.

Case study

Juliette (age 40) is a GP and operates as a sole trader. She is married with 2 children. Juliette takes a salary of $180,000 (a marginal tax rate of 38.5%). Upon consultation with her Adviser, Juliette would like to purchase the following combined life/TPD cover:
Term life: $2.5 million
TPD (any occupation): $1 million
The premium cost is $1,575 per annum. Juliette also holds TPD (Own occupation), Trauma and Income Protection outside of super.

Strategy analysis

While the premium for the Life/TPD cover is $1,575, if the policy is held outside of super, Juliette will need to pay in after tax dollars so the real cost is $2,561 p.a. ($1,575/0.615).

Alternatively, if Juliette holds the insurance through her superannuation fund the insured TPD amount would need to be grossed up to $1,140,000 to account for the approx. tax in the event of a TPD claim. However, although the level of TPD is increased, resulting in an increased premium, the overall annual premium costs are still only $1,678 (assuming the15% contributions tax is offset by tax deduction for insurance). When compared to paying for the premium outside of super the overall saving is $883 p.a.

Tips and traps

A condition of release will need to be met to receive the insurance proceeds when they are held via a superannuation structure. Hence we recommend using a split TPD definition so that you still have the flexibility of an "own" occupation definition outside of super.

The decision whether to take a disability benefit as a lump sum or pension/income stream will depend on the client's individual circumstances. Clients with large debts may prefer a lump sum, whereas it may be more appropriate for those who want to spread the receipt of money to take a pension. Often a combination of a lump sum and pension may be optimal.

Article written by Hayden White DFP & Cert IV Finance/Broking. For more information please contact Hayden at Poole Group on 07 5437 9900 or email hwhite@poolegroup.com.au

Metro North Maternity GP Alignment Program workshop

Saturday 28 March 2015 - UQ Centre for Clinical Research, Royal Brisbane and Women's Hospital

The six hours of education for the alignment program covers a number of important topics including:

- first trimester presentations
- recommended screening tests
- ultrasound scanning including nuchal translucency recommendations
- diabetes in pregnancy
- prescribing in pregnancy
- communication with Metro North birthing facilities
- models of care options
- Rh negative women
- hypertension
- pre-eclampsia
- early pregnancy bleeding
- reduced fetal movements
- immunisations
- depression
- postnatal care
- breastfeeding

Our presenters include a maternal fetal medicine specialist, general and obstetric physician, staff obstetrician, pharmacologist, physiotherapist, dietician, social worker, midwifery educators, lactation consultant, perinatal mental health nurse, continence nurse advisor, midwives and GPs.

By registering, you agree to participate in the full program, including completion of the 10 Q&A.

RACGP Accreditation

Category 1 QI&CPD Accredited Activity - 40 points

Closely aligned with existing Mater Mothers Hospital and Metro South GP Maternity Shared Care Alignment Program.

RACGP QI&CPD Accredited Activity CATEGORY 1

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Date

Saturday 28 March 2015

Venue

Auditorium, UQ Centre for Clinical Research, Royal Brisbane and Women's Hospital
Butterfield Street, Herston QLD 4006

Program

9:00am	Optional Tour of Women's and Newborn Services
9:30am	Registration and Morning Tea
10:00am	Workshop (with lunch and afternoon tea breaks)
5:00pm	Workshop concludes

Register online

www.mnbml.com.au/events-health-care-professionals

Registrations will close
Wednesday 25 March 2015

Workshop enquiries

Brigid Wheaton
Program Coordinator
Metro North Maternity GP Alignment Program
e mngpalign@health.qld.gov.au
p 07 3646 4421

This is a joint initiative between Metro North Hospital and Health Service and Medicare Local

medicare local METRO NORTH BRISBANE
Connecting health to meet local needs

Queensland Government

The PFO Again

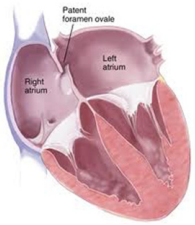
written by
Dr Roderick Chua
Interventional and Heart Failure Cardiologist

Embryological origins

The Patent foramen ovale is a congenital cardiac lesion that frequently persists into adulthood. It is found in 25-30% of individuals. During fetal development, the patent foramen ovale is required for oxygenated blood to flow from the right to the left atrium.

Starting from the fourth week of pregnancy, the septum primum and septum secundum begin to form and fuse. Eventually, the septum secundum overlaps part of the foramen secundum which is formed by perforations in the septum primum. This forms an incomplete septal partition that becomes the foramen ovale.

At birth, oxygen filling the lungs causes the pulmonary arterioles to open reducing the right heart pressure and pulmonary vascular resistance. This then raises the left atrial pressure which promotes fusion of the septum primum to the foramen secundum usually closing the foramen ovale by 2 years of age.



Clinical manifestations

Most patients with a patent foramen ovale (PFO) are completely asymptomatic. However, statistically there appears to be an increased prevalence of a PFO in patients with cryptogenic stroke. Paradoxical embolism from the venous circulation going through the PFO to the left heart is a known possible mechanism. On the other hand, having a PFO alone is not associated with an increased risk of recurrent stroke. Migraines and vascular headaches may theoretically be caused by right to left cardiac shunting through a PFO. Importantly though, routine screening for a PFO in patients in migraines is not recommended. Decompression sickness and venous air embolism through a PFO can rarely occur.

Diagnosis

A PFO is usually diagnosed via a transthoracic echocardiogram with or without an agitated saline bubble study to confirm its presence and establish a right to left shunt. A Valsalva manouvre increases right heart pressures which augments detection of the PFO. A transoesophageal echocardiogram can often be more sensitive in showing that a PFO exists. A cardiac MRI scan or CT scan can also be used to find a PFO.

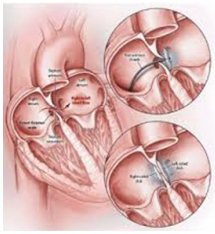
Relationship to stroke

Approximately, 30-40% of ischemic strokes are cryptogenic without a clearly identifiable embolic source and not due to small vessel cerebrovascular disease. The increased prevalence of PFO's in patients with cryptogenic stroke has mainly been seen in case control studies. Population based cohort studies which tended to include older subjects, was not able find a statistically significant association. Therefore, it remains controversial as to whether a PFO does increase the risk of stroke.

Prospective studies looking at the risk of cryptogenic stroke with PFO have given variable conclusions. The Risk of Paradoxical Embolism study 2013 performed a meta-analysis of 12 cryptogenic stroke cohorts. This showed that amongst over 3000 patients with cryptogenic stroke, the prevalence of a PFO correlated with the absence of vascular risk factors for stroke. However, the patients with the highest PFO attributable risk of stroke were also the ones that had the lowest risk of recurrence. Often, once age and co-morbid vascular conditions are accounted for, the presence of a PFO is found only to either be associated with a minor or non-statistically significant increase in the risk of stroke.

Treatment

The optimal treatment for patients with a PFO who have experienced cryptogenic stroke remains not well established. Risk reduction strategies such as blood pressure reduction, statins and anti-platelet therapy remains the mainstay of therapy. Best available evidence including randomized controlled trials have not proven the superiority of PFO closure over medical therapy. This is partly due to the fact that there is a small but definite complication rate associated with procedures to close the PFO and that most recurrent cerebral events are unrelated to paradoxical embolism.



A multi-centre randomized open label trial of percutaneous PFO closure as compared with medical therapy alone for patients between 18-60 years of age presenting with cryptogenic stroke on 909 subjects was published in the New England Journal of Medicine in 2012. The cumulative incidence of the primary end point was 5.5% in the closure group and 6.8% in the medical therapy group with respectively 2.9% and 3.1% stroke rates. There was no demonstrable benefit of PFO device closure vs medical therapy alone. Recurrent neurological events were usually due to causes other than paradoxical embolism.

Furthermore, a meta-analysis of 3 randomised controlled trials of device closure of PFO vs medical therapy alone showed no significant benefit of PFO closure and no significant risk reduction for ischemic stroke recurrence or mortality when an intention to treat analysis was conducted.

In summary

A patent forament ovale is a common coincidental finding in the general population. There is no clear evidence to suggest a frequent or definite association between the presence of a PFO and cryptogenic stroke. Most recurrent strokes are not due to paradoxical embolic events. There is no convincing study data demonstrating that closure of a PFO for secondary or primary prevention of stroke is any better than medical therapy and risk factor modifications alone.

JAPAN SKI CONFERENCE

By Cheryl Ryan

Just returning from our Japan Ski Conference I am missing the food already. Our small group of 8 guests enjoyed dining on traditional foods including sea cucumber and many other raw and unknown ingredients.

We all survived the challenges of trying different foods on the palate. Our dining included traditional Japanese foods but also French, Chinese, Italian and plenty of other great cuisines.

The conference was based around Customer Service and Japan did not let us down. Their attention to detail on every level was nothing less than exceptional.

We travelled North of Tokyo to a more remote and less known resort called Appi Kogen. Very few western people present with only one English speaking instructor who was in demand from all of us.

The slopes ranged from green (suited to me) through to Black Runs and for people wishing to venture a little further there were plenty of people heading off piste through the forest. The sun was shining; plenty of fresh snow and the slopes were not too busy.

Our days were spent on the slopes and our evenings spent in a private dining room where we enjoyed some great discussions and debates on time management, customer service and corporate ethics.

Getting naked with total strangers may not be your typical holiday pursuit, but don't be shy. The Japanese perceive bathing as a great social leveller and revel in the anonymity that nudity allows. The relaxation that follows a long soak after being on the slopes soon had me converted. However there is an etiquette that must be followed when entering.

A shower is taken before, during and finally the mineral water is left on the skin and not to be wasted. There is a small towel that is usually provided which is used when entering the area and then used for bathing but must not be taken into the water. Most of the ladies folded the towel and placed it up on top of their head.

Tokyo is always swirling with people and construction. New fads abound and the shopping and sightseeing is endless. A trip to Tsukiji Central Fish Market with 60,000 people employed is a hive of activity and so many varieties of fish you will not recognise.

The Tuna Auction visit will see you rise at 3am to get entrance into the 120 people limited viewing area. If you miss out a wander around the outside stalls is fascinating and hours can be passed.

Of course a visit to Japan would not be complete without a visit to the Sumo Wrestling held in January.

If seeing the large grunting and sweating bodies is not your thing then try your hand at a cooking class, enjoy a tea ceremony or gown yourself in a Kimono.

It is all a lot of fun!

2016 is in the planning!!

www.123Travelconferences.com.au

THE BANKRUPT MIND

By Dr Mal Mohanlal

The Mind is Timeless and eternal so how can we have a bankrupt mind?

As I see it, it is the ego in the mind with its perception of chronological time that is the problem. The thinking process that we use with its verbalization ties us to the world of the past, present and the future. It makes us time travelers who believe that thinking will solve all our problems and who fear that if we stopped thinking, we might disappear from the mind altogether. Thus the thinking process in most individuals becomes a self sustaining process where one thought ends and another one begins. It becomes like a squirrel in a cage where one goes round and round in circles. It becomes a habit where one feels that one cannot stop thinking.

But do you know that our thinking process is very limited? One might be a genius, a great scientist or a philosopher, but the fact remains that our thinking is limited. Why? It is because all our thinking is based on the centuries of knowledge we have gathered from the world that we know today. Yes, we can think only in the terms of the known world not the unknown. Therefore, if we were to imagine what life forms could be found in a distant galaxy which is the unknown, we can only conjure up images of life from the shapes and sizes of creatures that we have discovered on our planet earth to date. We can run wild with our imagination but we will only be able to build a picture based on the creatures that we have known in this world and from the geometry of the structures we know. So to understand the Timeless or the Unknown one has to go beyond the thinking process that we know. The Timeless or the Unknown can only be appreciated when the thinking process becomes still on its own volition with the realization that it is limited.

Because our thinking process creates such confusion, chaos and conflict in our mind with its constant verbal chatter that we are forced to search for some inner peace. The techniques of meditation we have developed where we exclude all obtrusive thoughts and concentrate on one thing may give us temporary peace of mind. But it is a delusionary path because we fail to recognize the fact that the real purpose of meditation is to discover the Timeless dimension.

The Timeless is all round us and is always in the present. One does not have to go looking for it. It is a dimension in itself as real as the chronological time dimension that we have created and live in. The only thing that separates us from the Timeless dimension is our perception. Everyone experiences and has a glimpse of this Timeless dimension from time to time, but as we are too involved with our daily chores in time travelling we fail to appreciate it. However, if we were to move away from any man made structure at any given time, we will be in fact walking into the Timeless zone. So when one is taking a walk in the garden or in a park and if one becomes aware of it, one will soon start experiencing the timeless zone. In the wilderness it is even more overpowering and overwhelming. When the observer in the mind and what is being observed become one phenomenon, you are experiencing the Timeless dimension. Please recognize it and become one with it. Do not verbalize it; otherwise you will revert back into your own time zone. Look around, become aware and you will know what I am talking about. That is true meditation when one becomes aware of one's inner as well as the outer world. It is an all inclusive process, not an exclusive process. You will start experiencing and understanding eternity while you are still alive, not after you die.

So what is a bankrupt mind? It is a mind that perceives the truth in a statement, but then ignores it because it might affect the comfort zone that one has created for oneself. It is a mind that resists change for fear that if one did change, one might lose one's identity with all its associated beliefs and ideologies. It is a mind that is stuck in a groove steeped in traditions and philosophies with no insight into how one can go about freeing oneself from the web of time. It is a mind that is inflexible, unreasonable and contradictory that has lost its ability to listen.

Now if you think you have an open mind and willing to understand how you operate in this hypnotic world, I would urge you to read my book "The Enchanted Time Traveller- A Book of Self-knowledge and the Subconscious Mind". Mental illness is increasing in societies all over the world with its associated violence.

The Titanic is sinking. We as health professionals should be in the team that is handing out life jackets and helping people get into life boats, not joining the team that is rearranging decks chairs or playing the band on the ship. The first fifty pages of this book contain the secrets of the mind and therefore considered essential reading.

Be a true scientist, not a pseudo scientist. Visit website: **http://theenchantedtimetraveller.com.au/**

Fatigue

Dr Peter Davidson, Haematologist **Phone: 07 31214605**
Oncology Haematology Clinic **Phone: 07 3859 0690**

The symptom of fatigue can be associated with much pathology, but invariably for many patients it is often a symptom of poor lifestyle – as the Mars Bar advert says "Work/Rest/Play" i.e there is usually an imbalance with Overwork/ Poor Quality Sleep / Inappropriate Exercise Activity, and I would also add Inappropriate Ingesting (e.g. poor diet).

Nonetheless, when clinical history or family history raises concern it may be prudent to exclude organic pathology.

Typically, clinical history and exam should help rule out Cardio-Respiratory Disorders or Neuro-Muscular Disorders as a cause of fatigue and in particular exertional fatigue.

If a diagnosis is not clear basic pathology testing with E/LFT, FBC, TSH, and Iron Studies would be suitable for first-line screening. What is of relevance here it whether the patient is anaemic or not. Anaemia in itself is also a "symptom" – there is usually a cause, and although GI bleeding may be one cause, most anaemias are due to other disease processes.

Moreover, the non anaemic patient may still have fatigue related to suboptimal iron status. New Australian guidelines have suggested Iron sufficiency usually requires a ferritin of 30ug/L or more. Often patients (male or female) will be iron deplete with ferritins between 10-30, yet their Hb will be within the reference range – although a quick comparison with Hb levels from previous years may reveal a downtrend in Hb levels.

Iron is not only required for Haemoglobin function, but is also relevant in muscle myoglobin and intra-cellular enzyme function.

The FERRIM study was to determine the efficacy of intravenous iron compared with placebo in decreasing fatigue 6 weeks after treatment initiation in non-anemic patients with iron deficiency (serum ferritin ≤50 ng/ml). Fatigue was assessed using the Brief Fatigue Inventory (BFI; severity of fatigue) and the Short Performance Inventory (SPI; improvement in fatigue) questionnaires. Patients were followed-up for 12 weeks. Patients in the intravenous iron group reported improvement in fatigue (65% and 63% of patients after 6 and 12 weeks, respectively) significantly more often than in the placebo group (40% and 34% of patients after 6 and 12 weeks, p=0.02 and 0.006, respectively) as evaluated by the SPI.

Unfortunately, there is a subgroup of patients who continue to suffer long-term Chronic Fatigue not due to any obvious aetiology. One of the hallmarks of these patients is systemic exertion intolerance.

The disease known as chronic fatigue syndrome (CFS) has long defied classification, because the symptoms vary greatly in the millions of people who are affected by it. In February 2015 a panel commissioned by the US Department of Health and Human Services (HHS) produced an influential report on how the disease should be diagnosed. **The guidelines come with a new moniker: systemic exertion intolerance disease (SEID).**

The treatment of these various diseases related to fatigue will sometimes be fairly straight forward such as the provision of iron infusion for those patients with sub-optimal iron status. Yet other times, conditions such as SEID may require a more eclectic approach to therapy.

Dr Davidson offers IV infusion therapy at NLDH.

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

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Dear Doctors

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Where We Work And Live

Interesting Facts You Didn't Know About Valentine's Day.

The most popular theory about Valentine's Day origin is that Emperor Claudius II didn't want Roman men to marry during wartime. Bishop Valentine went against his wishes and performed secret weddings. For this, Valentine was jailed & executed. While in jail he wrote a note to the jailor's daugter signing it "from your Valentine".

In Victorian times it was considered bad luck to sign a Valentine's Day card.

Based on retail statistics, about 3 per cent of pet owners will give Valentine's Day gifts to their pets.

About 1 billion Valentine's Day cards are exchanged each year. This makes it the second largest seasonal card sending time of the year

Meant as an alternative to Valentine's Day, the holiday is for single people to celebrate or to commiserate in their single status.

Or you could pop over to Finland where Valentine's Day is called Ystävänpäivä, which translates into "Friend's day". It's more about remembering your buddies than your loved ones.

Many believe the X symbol became synonymous with the kiss in medieval times. People who couldn't write their names signed in front of a witness with an X. The X was then kissed to show their sincerity

In 1537, England's King Henry VII officially declared Feb. 14 the holiday of St. Valentine's Day.

Richard Cadbury produced the first box of chocolates for Valentine's Day in the late 1800s.

Physicians of the 1800s commonly advised their patients to eat chocolate to calm their pining for lost love.

73 percent of people who buy flowers for Valentine's Day are men, while only 27 percent are women.

Red roses are considered the flower of love because the color red stands for strong romantic feelings.

http://list25.com/25-interesting-facts-valentines-day/

RDMA's February Invitation

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: Tuesday 24th February 2015

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: MyIVF
7.40pm	Speaker: Dr John Chenoweth Topic: Low cost Fertility Treatment: My IVF – Patient selection, preparation and results achieved.
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 20 February

QML Pathology.