RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
JULY 2016

Immigration and Immigrant Ships Continued: Moreton Bay Part III Story of the "Queen of Colonies https://espace.library.uq.edu.au/view/UQ:241112/s18378366_1935_2_6_304.

See Where We Work & Live on page 20. The Queen of the Colonies Continues:

President's Report Dr Kimberley Bondeson

Welcome to winter! Finally, the cold weather has come with a vengeance.

On the Redcliffe Peninsular, we are experiencing cold weather and beautiful sunny days (most of the time), though unseasonal rain is predicted. There is snow in New South Wales and parts of Queensland.

School holidays are over, and life is almost back to normal. T

he Federal Election has been and gone, with an interesting result – Malcolm Turnbull and his party were re-elected, but not with the majority they were hoping for.

It is still uncertain if we have a new Federal Health Minister or not.

In reading the local newspapers, in the new Senate, the Prime Minister will have to have agreement from up to 6 independents, eg. Senator Pauline Hanson, Senator Derryn Hinch and Senator Jackie Lambert, who were voted in, in order to get any Law Reforms passed.

At this stage, I am unaware of any of these particular Senators having any Public Health Policies.

Following the recent election, there has been increasing calls on the Federal Government to drop the freeze on bulk billing – will this survive caucus or a hostile senate?

Australia has one of the most enviable health care systems in the world. However, total health spending has more than doubled as a share of domestic product since 1964.

The cost of public healthcare is continuing to rise (growing well above the inflation rate) with an ageing population which is living longer, new technological developments and expensive medications being blamed. Obviously measures that we are able to put in place now need to be designed to benefit the future generations.

On another note, Britain has voted to exit the European Community (Brexit), and has a new Prime Minister. America is still campaigning for a new President, to be voted in later this year.

So the world is changing and evolving, some good, some uncertain.

Kimberley Bondeson
RDMA President

RDMA & NLMA's Joint Newsletter

Welcome from
Dr Robert (Bob) Brown
President Northside Local Medical Association

QML Pathology. | Redcliffe Laboratory
Partnering with Redcliffe & District Medical Association for more than 30 years.

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 Contacts:

President:
Dr Robert (Bob) Brown
Ph: 3265 3111
E: drbbrown@bigpond.com

Vice President:
Dr Ken Fry
Ph: 3359 7879
E: kmfry@bigpond.com

Secretary:
Dr Ian Hadwin
Ph: 3359 7879
E: hadmed@powerup.com.au

Treasurer:
Dr Graham McNally
Ph: 3265 3111
E: gmcnally1@optushome.com.au

Meetings' Convener: TBC
Dr Graham McNally
Ph: 3265 3111
E: gmcnally1@optushome.com.au

RDMA 2016 MEETING DATES:

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

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Wednesday	February	24th
Tuesday	March	29th
Wednesday	April	27th
Wednesday	May	25th
Tuesday	June	28th
Tuesday	July	26th
ANNUAL GENERAL MEETING - AGM		
Wednesday	August	24th
Tuesday	September	13th
Wednesday	October	26th
NETWORKING MEETING		
Friday	December	2nd

RDMA NEWSLETTER DEADLINE

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

NLMA 2016 MEETING DATES tbc:

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

W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants

Time: 6.45 pm for 7.15 pm

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

Next Meeting Date 26th July 2016

28.06.16 Dr Kimberley Bondeson, President Redcliffe & District Local Members Association introduced Vicki Goss and Kenton Thompson the Iconcore Sponsor Representatives for the night. Iconcore Sponsored the speaker for the night. Dr Michelle Jalilan, Topic: 'Breast & Skin Cancer, A General Practitioner Overview".

Below Top Down:
1. Speaker Dr Michelle Jalilan, 2. Geoff Hawson, long time RDMA Member and AMAQ Councillor: Retired Group Rep
3. Iconcore Reps; Vicki Goss and Kenton Thompson with Speaker Michelle Jalilan centre.
4. New Attendee: Ken Mills & Michael Cross,
5. Ray Collins & Andrew Butler.

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 26th July**

TIME: 7 for 7.30pm

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

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

AGENDA:
7.00pm Arrival and Registration
7.30pm Be seated - Entrée served
Welcome by Dr Kimberley Bondeson - President RDMA Inc.
7.35pm Sponsor: Montserrat Day Hospital
7.40pm Speaker: Dr Daniel Timperley
Topic: "The Role of the ENT surgeon in Obstructive Sleep Apnoea".
8.15pm Main Meal, Question Time
8.40pm General Business, Dessert, Tea & Coffee

RSVP: By Friday 22nd July 2016
(e) Margaret.macpherson@qml.com.au (t) 07 3049 4444

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INSIDE THIS ISSUE:

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DR CAROLE GAHAN P/N 352736J
M.B.,B.S. (Qld)

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Email: larryg82@hotmail.com
Phone: Mobile: 0402202486 / 07 3265 7500

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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

AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

Election 2016 and Brexit

No matter which way you swing, the 2016 Federal election was a disaster. The Coalition came within a whisker of losing power, the ALP came within a whisker of enduring another minority government, only one of the minorities actually made an impact (and the Xenophon party is really only relevant to one of our smallest states) and nobody has a mandate. Both sides will claim that they have a mandate, but really neither has the confidence of the people.

And a lot of the knife-edge outcome can be blamed on a blatant lie, the false basis to the Mediscare campaign. The Coalition did plan to weaken Medicare by freezing rebates, but they denied any intent to privatise Medicare (and that might not have been a bad thing for the country if they did, but it involved slaughtering the most sacred of sacred cows).

What is ultimately important about the Mediscare campaign is
(a) that the ALP got away with it, and
(b) the Coalition did not successfully counter the underlying mistruth, and when they did raise a feeble response they were not believed.

At AMA National Conference a month ago, all the experts told us that health was a number one issue for all voters. But it never gained traction in the campaign until the very end. Both sides concentrated on the economy and job security, or at least that was all that the media fed to the mug punter. It was only in the last week or so that Mediscare emerged, and it was never truly debated.
So what do we have? We have a weakened and emasculated Coalition that will claim that they won, so they have a mandate to freeze rebates. But they know how risky that is, and if they have a eye to the next election (which Bill Shorten asserts will be a snap election in the near future) they might lack the courage to anger the voting public any more. Hospital funding is in limbo, because I cant see any coherent policy that makes sense and will be bought by the State governments.

I suppose the other contentious issue close to the hearts of doctors is the proposal to change the tax benefits of superannuation, to limit the quantum to a figure that is more appropriate to a public servant than to a self-employed professional. What is most contentious is the proposal to make the changes retrospective and by a huge amount. If this happens, nobody planning a financial future will be able to make any confident decisions, when the rules can be changed ten years from now to take away what was given today.

After the closest-possible result, the AMA is again stating that health will have centre stage in the public view. They will be watching closely to see how an impoverished government approaches the problems faced by emergency departments and aged care. Inevitably, we ourselves will also watch this space with close interest.

BREXIT.
The entire world was caught by surprise when the Brits decided to leave the EU. What is often described as Independence Day was strongly influenced by a refusal to keep subsidizing the poorer cousins of the EU and by a determination to determine their own immigration policy. Does this have implications for Australian medicine?

At the most superficial level, for those who want to work overseas, it will probably be easier to get training places or simple medical tourism places in the Old Dart, much as it was when I was a lad.

More profoundly, the vote reflects a xenophobia that was probably much stronger than any suspected, following so closely in the steps of the Muslim invasion of Europe and ISIS-inspired violence in multiple events in recent history. I cannot help but wonder how closely this is mirrored in Australian sentiment. Our stop-the-boats policy, debate over refugee management, and vocal left-wing minorities constantly raise questions about our relationships with those who seek to bring foreign cultures into conflict with our dominant culture. What we are seeing in Australia is a war, a war fought with social weapons and not hard weapons, but a war nevertheless. As doctors, we cannot sit on the sidelines as spectators but must actively participate to care for the casualties of a novel form of warfare.

As always, the views expressed herein are those of your correspondent,
Wayne Herdy.

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Federal Election,

We now have a new Federal Government in power after the recent election. To date, we do not know if we will have a new Federal Health Minister or not.

The current policies of the Federal Government are very harsh on Health.

Whether these continue, after the recent election campaign is to be seen.

It would be a very brave (or foolish) Federal Government to continue to push for privatisation of Medicare, or to continue to cut funding to hospitals and to Medicare.

As far as information on the plans for privatisation of Medicare goes, what we do know is that the Turnbull Government paid $5 million to have one of the computer companies look at upgrading the current Medicare Billing System.

We also know that the Bowel Screening has been taken over by a private company, and that this has been outsourced overseas.

This could be seen as an initial "privatisation", or "outsourcing" of Medicare by the public, who are concerned that this chipping away at publically funded health services, transfer to private enterprise, and subsequent outsourcing to cheaper, overseas services will eventually be widespread among Medicare Services.

It was on this basis that the opposition based part of their election campaign recently, and which, by all accounts in the media, the public responded to.

Medicare Billing Services are undoubtedly old and outdated, and at some stage will require updating like the current Australian electoral voting paper based voting system, which the Australian public has just gone through.

Both these systems will be expensive to update.

A major concern with Medicare is if this "updating" involves outsourcing to overseas companies, which would involve major privacy concerns, let alone taking employment opportunities away from the Australian public.

Personally, I don't think there is anything wrong with using an old system, as long as it works.

Any upgrades should be taken very slowly and carefully.

Look what happened to the Queensland Health payroll system.

If this occurred with Medicare claims and payments, the health system in Australia is likely to collapse.

Hospitals, doctors, patients and allied health claims would not go through, and rebates would not get paid.

Purchasing medications would be affected and the public would not be happy.

Sincerely

Kimberley Bondeson

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Meet Our Team

Dr John Reardon
Medical Oncologist/
Clinical Haematologist
***SC**

Dr Hong Shue
Medical Oncologist
***SC**

Dr Sorab Shavaksha
Clinical Haematologist
***SC**

Jesse Goldfinch
Excercise Physiologist
***SC**

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

Dr Peter Davidson
Consultant Haematologist
***NL**

Dr Kieron Bigby
Medical Oncologist
***NL**

Sarah Higgins
Dietician/ Nutritionist
***SC**

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

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

Tania Shaw
Oncology Massage Therapist
***SC**

Dr Raluca Fieser
Clinical and Laboratory Haematologist
***NL**

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

Be Our Guest

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

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

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

AUSTRALIAN MEDICAL ASSOC PRESIDENT
DR CHRIS ZAPPALA

MEMBER'S UPDATES

Dear Members,

Political uncertainty is maybe something we must endure in Queensland. We have a minority State Government and, after prolonged federal uncertainty that only served to extended a fatiguing campaign beyond reasonable bounds, we have a bloodied and tenuously re-elected Commonwealth Government. The recent election campaign and current political landscape highlight the importance of health to voters and raise the more prickly issue of how best to engage with voters (patients) on political issues.

The Medicare rebate freeze became an increasing topic of debate (hysteria?) as the Federal Election campaign progressed, with both parties making accusations about the other's intentions without actually presenting a viable Medicare model themselves.

Into this fracas the AMA crept with its 'end the freeze campaign.' We all know why this is important for doctors and to underpin high quality medical care for patients, while still allowing protection of the vulnerable. Despite this, I received a small number of complaints about this campaign and I think it useful to discuss further.

The main concern the couple of dissenters had was that our message preferentially needs to be centred upon having patients acquiesce to a small payment for a quality service and that the campaign amounted to 'support' for bulk-billing – which is killing general practice (either financially or in regards to its credibility and quality).

As we reflect on our campaign, and the election, there are several conclusions to be drawn:
1. The media message of an organisation represents a succinct and captivating point to pique interest – it is not a distillation of everything believed in. I recognise that ending the Medicare freeze would not be the end of our woes. It is hoped however that this message is a useful catalyst to open up wider discussion.
2. If doctors are to successfully persuade politicians and the public (our patients) about responsible, even-handed healthcare funding reform, we need to recognise and be aware of the medico-political milieu in which we operate and tailor our message accordingly.
3. We need, as a profession, to ensure we have the weight of evidence and 'the high moral ground' on our side, but never pretend that this alone is sufficient to win the day.
4. What happens now to Medicare, co-payments and bulk-billing is anyone's guess.

The extension of these musings is that we can't turn a blind eye to poor performance or inferior standards of care. We cannot sacrifice good clinical governance or compromise patient outcomes in pursuit of income. 'Conveyor-belt' bulk-billing medicine compromises our integrity and when we tolerate it we look foolish. At the very least, it thoroughly cripples any ability we might have to argue for positive reform beyond 'end the freeze'. How can we argue for an end to the rebate freeze if a 'popular' model of care focuses on patient throughput and income, rather than the quality of care provided? This internal conflict within our profession represents our greatest risk and vulnerability.

I do not disagree with unease about a simple 'end the freeze' slogan, but this is not the full extent of our advocacy. AMA Queensland will continue to enhance our own credibility, sharpen our political antennae and deliver consistent, positive and tailored campaigns that focus on patient safety and quality of care.

Just quickly, at the state level, we are glad to see a bit more cohesion around public health, with the new alcohol trading laws recently implemented. The last few years have seen increasing rates of alcohol-fuelled harm, particularly in regards to alcohol-fuelled violence. Our emergency departments are one group of clinicians who have seen the effect of this.

Trading hours restrictions have proven effective in other states and countries that have implemented similar measures and are an important step towards changing Queensland's relationship with alcohol. While there is still more to be done, AMA Queensland is optimistic that these measures will be an important first step. We will continue to keep you updated as any information about the success of the measures becomes available.

Sincerely

Dr Chris Zappala
AMA Queensland President

https://2016varietybash.everydayhero.com/au/wayne (Donations listed)

Left: Dr Wayne Herdy's wife cum practice nurse Monique, and his practice manager Kelly Howard get into the spirit of fundraising for Variety the Children's Charity.

Dr Wayne Herdy is registered to participate in the 2016 Variety Bash. He has bought a 1986 Mercedes Benz 280SE (cost $800!) and his co-driver has been working to get it roadworthied and registered. It is now registered and on the road. The 2016 Bash will start in Warwick on Friday 30th September and finish in Bathurst on Saturday 8th October, the day of the big race.

Donations are most welcome, tax deductable and easily made via the internet: To make donations, go to **https://2016varietybash.everydayhero.com/au/wayne**

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- Holistic approach to cancer care
- Free on-site parking

Experienced team of doctors:

Dr Jason Butler
Clinical Haematologist

Dr Robert Hensen
Clinical and Laboratory Haematologist

Dr Michelle Jalilian
Radiation Oncologist

Dr Haamid Jan
Medical Oncologist

Dr Ashish Misra
Clinical Haemato-Oncologist and Bone Marrow Transplantation

Dr Manoja Palliyaguru
Radiation Oncologist

Prof Andrew Perkins
Clinical Haematologist and Medical Oncologist

Dr Jason Restall
Clinical Haematologist and Haematopathologist

To refer a patient please contact us on:
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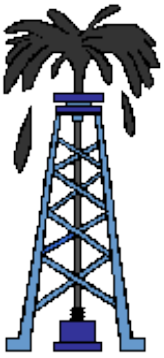
"Oil Spills"

25 years ago Iraqi forces opened oil valves to impede the troops trying to liberate Kuwait. What unfolded was easily the biggest oil spill in human history with 4,000 square kilometres of Kuwait covered in a 10 cm thick oil slick.b4 million barrels or 480,000 m³ of oil spilled out onto the land and sea. It was almost enough oil to fill Sydney Harbour.

About 50% of the volume evaporated, 25% was recovered and the rest is still sitting there with a lot of oil that entered waterways washing up on Saudi beaches. Quite a mess to clean up. Reminded of this I recently helped a colleague to clean up a much smaller oil spill in the rear foot-well of his Honda Civic. Seems that he'd bought 5 litres to do an oil change which he then completed.



The remaining 1.5 litres in the container didn't find a place on the shelf in his workshop, but rather was put back behind the driver's seat. Sometime in the next two weeks the container slipped side-ways and, can you believe it, the top wasn't sealed.

Discovering that there was one litre still left in the container, we estimated that the total spill was only 500 ml. But how do you pick up two cupful and put it back where it came from? The Internet was the obvious place to seek advice from. Absorbent paper towels did a good job in Step One, but the carpet still seemed sodden with oil and felt greasy no matter how many paper towels we used.

Step Two would necessarily involve a chemical attack, but that would have to be after the laborious job of removing the carpet from the vehicle. Most automotive carpets have a perforated backing so that dampness can dry out.
Those perforations are just as able to allow fluid to get under the carpet as well. Half a day was all it took to get the carpet out after the seats, door sills and centre console were removed.

Cleaning the shiny metal floor-pan was easy with just a rag and any old detergent. Cleaning the oil from the carpet was going to be a lot harder.
According to the Internet the best place to start was with Bicarb of Soda or sodium bicarbonate ($NaHCO_3$). Sprinkle it on, the crystals soak up the oil and then vacuum it up. Sorry, but that didn't cut the mustard though sodium bicarbonate is still a pretty good antacid. Next thing was dry cleaning fluid or tetrachloroethylene ($Cl_2C=CCl_2$).

A chemical solvent should dissolve the oil, but with the carpet fibres having such a big surface area there seemed to be no way of shifting the oil without flooding the carpet which might also be dissolved by the cleaner.

Next we tried degreasing oil. On paper this approach did look promising with a greater volume of solvent. In practise the carpet was just as greasy after de-greasing and to make matters worse, it now smelt like degreaser to boot.

Our final line of attack was with good old-fashioned amphiphilic detergent. Remember the hydrophobic "fat-loving" end of the detergent molecule would dissolve the oil which should then just wash away with water. As the spill had been in a car we started with car wash detergent.

Somehow it just didn't seem to cut the grease so we tried dish-washing detergent which similarly failed to impress. Whilst the process was gentle on our skin, the carpet still felt oily. With the options reducing and the distinct possibility of admitting defeat and ordering a new carpet on eBay for $200US we gave it one last try. Laundry detergent was never meant to be tested on humans or animals, but it was good for cleaning overalls. With more surfactants, enzymes and optical brighteners this had to work, and it did.

That corner of the carpet was now so clean it left the remainder looking decidedly dirty. So there was no other choice but to push on and remove the chocolate, mud and two litres of dehydrated Coca-Cola that was deposited elsewhere on the flooring.

Next job, Kuwait.

Mockery of Democracy

by Dr Mal Mohanlal

I am glad I am not a politician. They are constantly manipulating the system and distorting our perceptions.

In the recent Federal elections we saw democracy in action. It was compulsory voting otherwise you risked a fine.

Not only did you have to vote but you also had to give preferences 1 to 6 or 1 to 12 for the Senate and fill all the boxes for the House of Representatives. If you did not follow these guidelines your vote was invalidated. So what does this all mean?

It means that in a country like Australia you have to be literate, that is to be able to read or write. It also means that you are capable of using your brain.

Now if you are elderly, intellectually handicapped or visually impaired practicing democracy can be a very trying experience.

Recently I had cataract surgery and my near vision is now not as good as it used to be. Yes, on Election Day I found myself in the voting booth without my reading glasses.

You can imagine my embarrassment and frustration in trying to cast my vote on our complex voting paper. With difficulty I filled out all the boxes as required but I am still not quite sure whether my vote was counted as informal.

This leads me to question our system of voting. Why should we make it so complex? Why cannot we vote for only one candidate? And if we are going to have preferences why cannot we limit to only three candidates?

I understand that about 5% of the votes counted have been informal. This means that we have disenfranchised 5% of our voting population by having this complex voting system. It is clear the system is being manipulated by politicians and parties making deals among themselves. Is this not making a mockery of democracy? No wonder the public have become disenchanted with politics and politicians.

Interesting Tidbits **NATTY MOMENTS:**

Letter of Recommendation

1 Trevor Smart, my assistant programmer, can always be found

2 hard at work in his cubicle. Trevor works independently, without

3 wasting company time talking to colleagues. Trevor never

4 thinks twice about assisting fellow employees, and he always

5 finishes given assignments on time. Often he takes extended

6 measures to complete his work, sometimes skipping coffee

7 breaks. Trevor is a dedicated individual who has absolutely no

8 vanity in spite of his high accomplishments and profound

9 knowledge in his field. I firmly believe that Trevor can be

10 classed as a high-calibre employee, the type that cannot be

11 dispensed with. Consequently, I truly recommend that Trevor be

12 promoted to Executive Management, and a proposal will be

13 effected as soon as possible.

****Addendum The aforementioned was standing over my shoulder while I wrote this report. Kindly re-read only the odd numbered lines.**

The Medical Journal of Australia • MJA
MEDIA RELEASE

MORE MONEY NEEDED FOR GP RESEARCH

EMBARGOED UNTIL 12:01am Monday, 11 July 2016

THERE needs to be more investment in general practice research, particularly clinical trials in a primary care setting, according to the authors of a Perspective published online today in the *Medical Journal of Australia*.

Professor Tania Winzenberg, from the University of Tasmania, and Professor Gerard Gill, from Deakin University, wrote that multiple studies demonstrate how a strong primary health care (PHC) system correlates with greater efficiency, lower mortality and better health outcomes.

Despite this, "there is a mismatch between the burden of diseases commonly managed in general practice and the number of randomised controlled trials exploring their effective management, and between the frequency with which conditions are encountered in general practice and publication rates of research and clinical guidelines".

Often clinical trials are performed in a hospital setting as treatment benefits are usually higher in people at higher risk of adverse outcomes from their disease, they wrote.

When these benefits are applied in a primary care setting where the patient is of lower risk, it "may result in overtreatment or less cost-effective treatment".

Many GP research programs, including the Australian Primary Health Care Research Institute, the Primary Health Care Research and Information Service and the Bettering the Evaluation and Care of Health study, have recently lost or will soon lose funding, meaning there is less direct funding of PHC research than there has been for decades.

Obtaining funding for general practice research is a huge challenge, the authors wrote, with only 1.9% of National Health and Medical Research Council-administered grants between 2000 and 2008 related to primary health care.

The authors wrote that the Royal Australian College of General Practitioners had provided a pre-Budget submission to the federal government on prioritising GP research, which if implemented, would go a long way to improving the situation.

"In the meantime, we are in grave danger of wasting the investment made to achieve current gains in capacity, leaving our profession and the Australian population to make do with a severely restricted evidence base to support PHC in this country," the authors concluded.

Please remember to credit The MJA – this assures your audience it is from a reputable source

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CONTACTS: Prof Tania Winzenberg 0498 544 939

MONTSERRAT
— CANCER CARE —

First in to Queensland to reduce Chemotherapy induced hair loss with the Cold Caps/Scalp cooling treatment

One of the most frequent questions we hear from patients when they discover they need Chemotherapy is, Am I going to lose my Hair?

We are proud to announce that Montserrat Cancer Care are the first in Queensland to officially offer patients a scalp cooling treatment (Paxman) that can prevent Hair loss caused by certain Chemotherapy drugs. *The service will be available at our Sunshine Coast Clinic.*

The treatment is clinically proven to be an effective way of combating Chemotherapy-induced hair loss and results in a high level of hair retention. It can be used with all solid tumor Cancers that are treated with chemotherapy drugs such as Taxanes (eg docetaxel), Alklating agents (eg cyclophosphamide) and anthracyclines/DNA intercalating agents (eg doxorubicin). The treatment cannot be used with Haematological malignancies, cold allergy suffers, cold agglutinin disease, presentation of scalp metastases and disease requiring imminent bone marrow ablation chemotherapy.

How does it work? The Paxman system causes blood vessel vasoconstriction, which reduces blood flow in the scalp to 20-40 % of the normal rate, resulting in less chemotherapeutic drug being delivered to the hair follicles. The drug infusion rate across the plasma membrane is reduced therefore decreasing the drug dose level entering the cells around the scalp. The system has been treating tens of thousands of patients annually throughout the world with a success rate from 56% to 73%. Efficacy studies in the United Kingdom show 89% efficacy. A comprehensive Clinical evidence report can be found at: http://paxmanscalpcooling.com/the-system/clinical-efficacy

We will be offering this as an additional treatment to our patients who met the criteria at **no cost.** Patients from our North Lakes Clinic can attend our Sunshine Coast Clinic at no additional charge for this service.

Further information can be found at www.schoc.com or www.facebook.com (Sunshine Coast Haematology and Oncology Clinic Friends), at the Paxman website: www.paxmanscalpcooling.com or by calling Clinical Nurse Manager Kim McCullough on: (07) 5479 0000.

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

Kind Regards

Montserrat Cancer Care Team

**The Orbis Cooling machine*

With the modern advances in the medical profession we are all living longer.

Unfortunately, we are seeing the demands from society impact the elderly community. In 2014-15, there were 1.8m people aged between 45-70 who had to retire due to severe health concerns or age related deterioration.

It is at these times when hard choices have to be made to sell the family home, access services to assist with the basic living needs, move the elderly into the support of other family members' homes or meet the intense demands of caring from your own home.

In 2009, 94% of aging population before the impacts of major health conditions lived in private dwellings. This portion was comprised of 74% of people living with others (family) and 20% living alone.

In 2012, there were 2.7 million carers in Australia, of these, 769 800 (28.6%) were family members who took on the responsibility as primary carer. In most cases these primary carers are faced with the difficult decision to give up time from work and forego income to provide the basic living care needs.

Following this, there are 1.4 million business owners looking to retire in the next 10 years across Australia. They will have lifestyle decisions that need to be made i.e. downsizing the family home, impacts from rising living expenses and the expectation to finally meet some life objectives.

They will need a structured approach to deliver a comprehensive retirement plan.

Many do not realise that since Government changes were implemented in July 2014, it altered individual consumers need to pay for their own aged care; the amounts being demanded have been extravagant. People are paying up to $550,000 for Refundable Accommodation Deposit (RAD) for rooms smaller than their kitchen at home. In addition to this, if the consumer cannot pay for the room although are in the position to fund half the amount ($275,000), the balance due

($275,000) will be charged interest at a rate of 6.5 per cent or $17,875 per year. This

Kirk Jarrott: KJarrott@poolegroup.com.au
Don Poole: DPoole@poolegroup.com.au
Poole Group: (07) 5437 9900

interest payment is called a Daily Accommodation Payment (DAP).

If they are unable to pay the DAP it will accumulate as debt against the $275,000 amount they were able to contribute. When they die that unpaid DAP balance will be deducted.

For many these expenses are funded through the utilisation of their superannuation accounts. As at February 2016, Australia had over $2 trillion in superannuation assets and the average asset per Self-Managed Super Funds (SMSF) exceeded $1 million.

In terms of superannuation funds, they were the key buyers of domestic equities in 2015, purchasing $42 billion compared to $19 billion of buying by foreign investors. Super funds increase in buying comes after the minimal buying from FY12-FY14. This suggests super funds are viewing equities as offering the best prospects of a positive real return.

These recent legislation changes indicate a growing complexity with the aged care regime and the challenges it is creating for both advisers and their aging clients.

Our in house Aged Care Specialists take all financial implications into consideration in reducing that complexity and stress for you and your family.

"Hope is not a financial plan"- Ric Edelman.

Costa Rica's Caribbean Coast
A Rustic Heavenly Beauty

By Cheryl Ryan

The Caribbean Coast of Costa Rica is just as enchanting as its Pacific Coastline. With sunny, humid weather, serene beaches, extraordinary wildlife, and mysterious cloud forests, Costa Rica has is a magnificent place to visit. From fascinating sight of nestling turtles of Tortuguero, rafting in Rio Pacuare, and scuba diving in the coral reefs to relaxing at the black-sand beaches or, savouring its exotic cuisine, especially, rondón –the spicy seafood gumbo. Costa Rica's will create a memory worth remembering for the lifetime.

Marine Adventure
Costa Rica's marine world is teeming with spine-tingling variety of life.
1. Playa Ostional: Watch thousands of sea turtles paddle through the fine, white, sandy beach. Enjoy the delightful sight of these turtles lay zillions of ping-pong-ball-sized eggs at these gatherings, known as the arribadas.

2. Cahuita National Park: The marine reserve is where you can have the best snorkeling experience. Explore the beauty of the marine world– gorgeous coral reefs, shiny lobsters, nurse sharks, twirling octopi and over 100 species of fish. Also, discover the nearby 18th century slave ship that was once on its way to Limón.

Pristine Beaches and More!
1. Cacao Trails: Seated between Cahuita and Puerto Viejo de Talamanca in Hone Creek, the Cacao Trails is home to a lush botanical garden blossoming with heliconias and bromeliads, as well as chocolate museum where cacao is processed. You can also drop by the proximate small museums, which showcase the unique Afro-Caribbean culture. Explore the area by kayaking on the nearby Río Carbón.

2. Playa Negra: This long, black-sand beach maintained to the highest ecological standards is Cahuita's must-visit peaceful spot for swimming, and if you are a novice-surfer, it's an excellent choice for your exciting beach break!

3. Studio of Fran Vázquez: All you artsy folks can drop by this studio of a self-taught folk painter whose vibrant landscape acrylic paintings are immensely popular.

4. Refugio Nacional de Vida Silvestre Gandoca-Manzanillo: Called Regama, in short, the wildlife refuge is mainly composed of lush rainforest which is home to exotic flora and fauna. Pantano Punta Mona – an extensive swamp – has copious holillo palms, sajo trees and is a haven for waterfowls. Caribbean Costa Rica's only red mangrove swamp can also be visited in this refuge. The calm, unspoiled white sand beach of the area has a charming allure. This area is indeed nature-lovers' paradise!

5. Puerto Viejo de Talamanca: A popular seaside destination, Puerto Viejo is lively not just for its spectacular beaches, but also for the mouthwatering Caribbean cuisine. Savour the Caribbean delicacies at Restaurante Elena Brown. Go diving, snorkeling, kayaking, mountain biking, boogie boarding or, insane surfing at the famed Salsa Brava Beach.

What have we planned for you?
A comprehensive itinerary has been developed to include all the exciting attractions of Tanzania.
• A guided tour to Playa Ostional's wildlife refuge during an arribada
• Trip to the Cahuita National Park, and snorkeling opportunity to explore the underwater creatures
• Trip to the Cacao Trails, which includes the garden, museums, the proximate organic farm and Río Carbón
• Guided hiking of the Regama reserve with an overnight tent stay
• Trip to Puerto Viejo de Talamanca's beaches

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GUIDELINES: UTI DIAGNOSIS AND MANAGEMENT IN CHILDREN

by DR PRASANNA SHIRKHEDKAR, FRACP, Paediatrician,
North Lakes Bnorthpaediatrics@gmail.com

Diagnosis and Management of urinary tract infections in children, particularly very young children can be a difficult topic due to changing guidelines, and difficulty obtaining clean urine samples.

The RCH Melbourne and NICE- UK guidelines remain popular and widely followed guidelines in Australia. I wish to highlight KHA – CARI guidelines as they are Australian national guidelines. CARI (Caring for Australasians with Renal Impairment) is a website maintained and supported by KHA (Kidney Health Australia – kidney.org.au) and ANZSN.

These guidelines are available at: http://www.cari.org.au/CKD/ckd_guidelines.html. The guidelines are divided into 4 subtopics and each one also mentions recommendations from other international organizations for comparison (CARI guidelines are the latest, others are much older updates).

For the purpose of brevity, I have compiled some salient points from CARI and RCH Melbourne guidelines that may be useful in the settings of general practice. Many of these recommendations are based on review of available evidence and panel consensus.

UTI: defined as the combination of symptomatic evidence of infection of the urinary tract (including one or more of: abdominal pain, dysuria, frequency, fever, loin pain and irritability in infants) in association with a urine sample containing a positive bacterial culture.

ACUTE PYELONEPHRITIS: bacteriuria in the presence of fever (>38oC) plus or minus loin pain/tenderness LOWER UTI: bacteriuria without fever or loin pain, but with localising signs such as dysuria, frequency, urgency and lower abdominal discomfort

DIPSTICK, MICROSCOPY, ASYMPTOMATIC BACTERIURIA And BAG SPECIMENS: Dipstick and urine microscopy have poor sensitivity and specificity under the age of three years. Yet, one must also remember that 2% of children will have asymptomatic bacteriuria and this may not be the cause of an acute presentation (red Herring). Finding a UTI in a sick child does not exclude another site of serious infection. (eg meningitis)

Australian guidelines do not support practice of BAG specimen urine collection for bacterial culture due to contamination risks and subsequent delays in diagnosis and management of that presentation. Clean catch urine is accepted method in children who can't void on request.

PRESUMED UTI: CARI recommend starting treatment for presumed UTI in children who have clinical symptoms suggestive of UTI and who have positive leukocyte esterase or nitrite on urinary dipstick testing or bacteriuria on microscopy. This assumes that the urinary specimen has been sent for culture.

ORAL VERSUS IV ANTIBIOTICS: For acute pyelonephritis oral treatment may be used if the child:

- Is at low risk of serious illness (as defined in the scope of guideline);
- Does not appear septic;
- Is able to tolerate oral medications. (1C)
- Lower UTI (cystitis): CARI recommends short duration oral therapy (2-4 days) (1A)

IMAGING FOR UTI:

A) FIRST UTI: CARI guidelines do not recommend routine renal tract imaging following a first urinary tract infection (UTI) except in the circumstances described below.

Children with concurrent bacteraemia;

- Are less than 3 months of age;
- Have a urine culture with atypical organisms (e.g. Staph aureus or Pseudomonas);
- Lack a clinical response to 48 hours of antibiotic if sensitive organism;
- Have renal impairment or significant electrolyte derangement;
- Have an abdominal mass;
- Have a poor urinary stream.

(different sub-categories and details of this topic in other guidelines – eg American, European, NICE-UK and Indian Academy of Paediatrics)

B) MCUG (Micturating Cysto Urethro-Gram) in children with recurrent pyelonephritis or those who have bilateral hydronephrosis or bladder wall thickening on ultrasound

C) DMSA scan is recommended if there is clinical concern for reduced renal function. It should be done 3 months after the UTI. (should not be done within 4 weeks of UTI)

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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/

AMA CONGRATULATES COALITION ON ELECTION VICTORY

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA today congratulated Prime Minister Malcolm Turnbull and the Coalition on their
election victory.

AMA President, Dr Michael Gannon, said that health policy was a key factor in the closeness of the election result, and the AMA looked forward to working with the Government in its second term on health policies that best serve the needs of the Australian population.

"While Opposition Leader Bill Shorten has conceded defeat, and the Prime Minister has claimed victory, the final seat count is still not known," Dr Gannon said.

"The new Government is yet to be sworn in, and the Prime Minister is still working on the new Ministry, but it is now predicted the Coalition will form Government in its own right, albeit with the narrowest of majorities.

"The election result and the prominence of health issues in deciding votes mean that the Government will need to review its health platform. This is something that Prime Minister Turnbull has already admitted.

"The Government should immediately lift the freeze on Medicare patient rebates, scrap changes to bulk billing incentives for pathology and medical imaging, and increase public hospital funding.

"The AMA agrees that health funding must be sustainable well into the future, and this will require a sector-wide examination of approaches to prevention, public health, the ageing population, and the significant increase in the incidence of chronic and complex disease.

"This will require investing more, not less, in primary health care, and keeping people out of more expensive hospital care where possible.

We need to find a way to sustainably fund the health system but, at the same time, we must protect the health of the most vulnerable in our community."

Dr Gannon said the AMA wants the Health Minister to have a very strong voice in Cabinet to ensure that health policy is not dominated by the considerations of the Department of Treasury or Finance.

"The election result has sent a strong message to the Government that Australian voters take Medicare and Health Policy in general seriously," Dr Gannon said.

"There must be a strong champion for health in Cabinet to drive policy that appeals to the electorate and medical and health professionals," Dr Gannon said.

The AMA will seek meetings with the Prime Minister, the Health Minister, the Shadow Health Minister, and other Parliamentarians at the earliest opportunity.

11 July 2016

CONTACT:
Kirsty Waterford
02 6270 5464 / 0427 209 753

John Flannery
02 6270 5477 / 0419 494 761

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Immigration and Immigrant Ships Continued: Moreton Bay Part III Story of the "Queen of Colonies"

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

"Queen of the Colonies." continued
The "Commodore Perry" brought 82 full-paying passengers and 545 immigrants—627 in all. (Captain Owen's son —Mr. David Owen, M.A.—a scholar of undoubted attainments, and an acknowledged authority on the Welsh language and literature—lived in Brisbane up to the time of his decease a few years ago. Captain Daniel Owen met his death in 1869, when the ship "Calcutta" was abandoned in the English Channel under circumstances already narrated.

Wreck of the "Netherby."
This Captain Owen had a brother, Owen Owen, who had command of more than one ship engaged in bringing immigrants to Australia. He was unfortunate enough to be in charge of the only one of the Black Ball ships to be wrecked while coming out to Moreton Bay with immigrants. It was a significant fact that during the eight years the Black Ball line held the Queensland Government contract for the conveyance of immigrants to the colony a complete immunity from real disaster was enjoyed. Although Captain Owen Owen's ship (the "Netherby") was wrecked on King's Island, Bass Straits, in 1866, all the passengers were safely landed and promptly brought on to Moreton Bay, their destination.

Remarkable Salvage Feat.
There was a sailing ship called the "Everton," which brought 340 immigrants out to Moreton Bay from Birkenhead early in 1863, whose story is a remarkable one. She passed through experiences here in which, while her own life was most miraculously saved, she completely lost her identity. Launched at Miramichi, New Brunswick, in 1861, the "Everton" was practically a new ship when she reached Moreton Bay.

After having landed her passengers and a quantity of cargo, she was in readiness to leave for Newcastle, for which port she had some railway material. While she was still in the bay, however, a gale sprang up and later blew so fiercely that she dragged her anchors and drifted across a sandbank towards the Ship Patch on Moreton Island. A little later it was decided to beach the vessel to save the lives of the crew. Her back appeared to be broken, and there were holes in the hull through which the water flowed in and out, with the rise and fall of the tide. The vessel was surveyed and condemned as unseaworthy, A week or so later, however, another attempt was made to repair her and, in the face of tremendous difficulty, this eventually proved successful. The "Everton" was purchased by R. Towns & Coy., of Sydney, who renamed her the "Lady Bowen," and she subsequently had 24 years of useful, seafaring life.

Ship with Two Lives.
The annals of the sea are full of thrilling stories concerning the lives of individual ships; but surely none more remarkable than that of the beautiful "Darling Downs." This was another instance of a ship having been given a name as a special compliment to Queensland, The "Calcutta" (that was the original name of the "Darling Downs") left Plymouth on February 5, 1869, having stowed in her hold 270 miles of telegraph cable intended to be laid from Bushire across the Persian Gulf,

Shortly after midnight, on February 7, in a terrific gale, the "Calcutta" came into collision with the Prussian barque "Emma," and the latter sank almost immediately. The "Calcutta," which was built of iron, having been originally a steamship, had a large hole in her bow, through which water was pouring in fast, and although every effort was made to cope with the leak by pumping, it was finally decided to abandon the ship.

Captain Daniel Owen, to whom I have already referred more than once, was in command of the "Calcutta," but he unfortunately lost his life, together with 26 others, after leaving the ship's side. The tragedy, however, had a most surprising sequel, for the "Calcutta," while still being tossed about in a terribly battered condition, was picked up by "H.M.S, Terrible" and towed into Plymouth. After she had been extensively repaired and reconditioned the ship's name was changed to "Darling Downs." She made one voyage out to Moreton Bay with immigrants, under Captain D. R. Bolt, arriving on November 5, 1874, and several times afterwards carried passengers from London to Sydney. In 1887 she was sunk off the Nore after a collision with another vessel.

Continued next month: