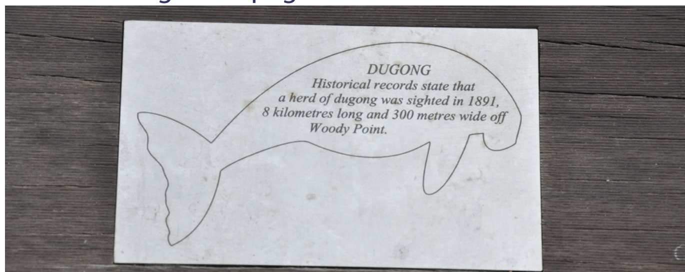
Newsletter

MARCH 2012

Woody Point

See Woody Point and surrounds featuring in our Historical Pictorial in this edition page 3 and the history of Woody Point Jetty page 5 and our regular Where We Live And Work segment page 20



RDMA President's Message ... Dr Wayne Herdy

The people of Queensland have delivered a historic electoral result, an unprecedented majority and an Opposition that doesn't meet the definition of a parliamentary party.

There will be a change in direction for Queensland Health. We hope to see the end of the pay system debacle. We hope to see a larger residue of the childrens' hospital survive at Royal Brisbane Women's Hospital, not a complete concentration of paediatric services in the South of the river (in the electorate of the former Premier). We hope to see a shrinking of the bureaucracy and a higher proportion of health dollars in clinical services.

With such a massive majority, there is a fear that the government will be complacent and arrogant. What we expect to see is a Health Minister who will listen and who understands the portfolio. As I write, the most likely candidate is Mark McArdle, from our near North at Caloundra. He does know the portfolio and so far has been a keen listener to the medical profession. It remains to be seen if the Minister will be as receptive despite the size of the government's majority.

With such a small Opposition, one wonders how it could have any real impact. It will take (unless the government makes a massive mistake) two electoral cycles before the Opposition has any muscle. Each shadow Minister will have multiple portfolios – whoever is burdened with Health will have other distracting duties.

Local Health and Hospital Networks will still have Ministerially appointed Boards – but now the list of preferred candidates will look substantially different from those that an ALP government would have selected.

One electorate that must interest the medical profession is Stafford. No longer held by an ALP Minster, it has been claimed by Dr Chris Davis, a past president of AMAQ. Chris will doubtless become a significant voice, more likely behind closed doors than in a public forum in his first term, in directing the government's policies and actions in health.

Interesting times indeed.

Wayne Herdy

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

QML Pathology. | Redcliffe Laboratory

Partnering with Redcliffe & District Medical Association for more than 30 years.

DATE CLAIMERS:

For all queries contact Margaret MacPherson Meeting Convener: Phone: (07) 3049 4429

Venue: Golden Ox Restaurant, Redcliffe
Time: 7.00 pm for 7.30 pm

2012 Dates:

NEXT MEETING

Wednesday March 28

Tuesday April 24

Wednesday May 30

Tuesday June 19

Tuesday July 24

Annual General Meeting
Wednesday August 29

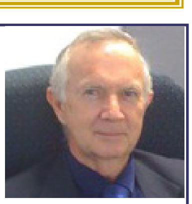
Tuesday September 18

Wednesday October 24

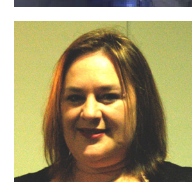
Year End Networking Function

Friday November 30

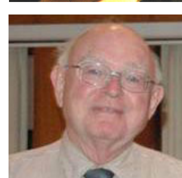
CONTACTS:



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



Vice President:
Dr Kimberley Bondeson
Ph: 3284 9777



Secretary:
Dr Ken Fry
Ph: 3359 7879

Treasurer:
Dr Peter Stephenson
Ph: 3886 6889

Meetings' Convener:
Mrs Margaret MacPherson
Ph: 3049 4429

Newsletter Editor: Dr Wayne Herdy
Ph: 5476 0111

For general enquiries and all editorial or advertising contributions and costs, please contact: RDMA Newsletter Publisher. Please email (preferred) any correspondence to:

Email: RDMAnews@gmail.com
Website: http//www.rdma.org.au
Mail: RDMA, PO Box 223, Redcliffe 4020
Fax: (07) 5429 8407
Mobile: 0408 714 984

APRIL NEWSLETTER 2012

The 17th APRIL 2012 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com
Website: http//www.rdma.org.au

INSIDE THIS ISSUE:

P 01: i) Woody Point & Surrounds
ii) President's Message

P 02: Date Claimers, Contacts and Contents

P 03: Woody Point Pictorial

P 04: AMAQ President's Report, Dr R Kidd and Classified

P 05: History of Woody Point Jetty

P 06: RDMA's Meeting & Invitation

P 07: AMAQ & Federal Branch Councillor's Report

P 08: Snapshot from the Past, RDMA Newsletter 1990 Issue
11 Historical Article – Redcliffe's New Super Acts

P 10: Interesting Tidbits - Natty Moments

P 11: Dr Clive Fraser – Holden VN Commodore "Another One Bits The Dust"

P 13: Microscopic Colitis – Dr Sam Islam

P 14: Bullying What You Need To Know AMA Brochure

P 15: Bullying - What is Bullying?

P 16: Microscopic Colitis Continued – Dr Sam Islam

P 18: AMA Takes Action To Prevent Bullying

P 19: Membership Subscription

P 20: Where We Work And Live

Disclaimer: Views expressed by the authors or articles in the Redcliffe & District Local Medical Association Inc Newsletter are not necessarily those of the Association. The Redcliffe & District Local Medical Association Inc accepts no responsibility for errors, omissions or inaccuracies contained therein or for the consequences of any action taken by any person as a result of anything contained in this publication.

Woody Point

WOODY POINT
VILLAGE

ATTENTION AMA MEMBERS

In the next month, you will be receiving ballot papers to elect your AMA Federal Councillors.

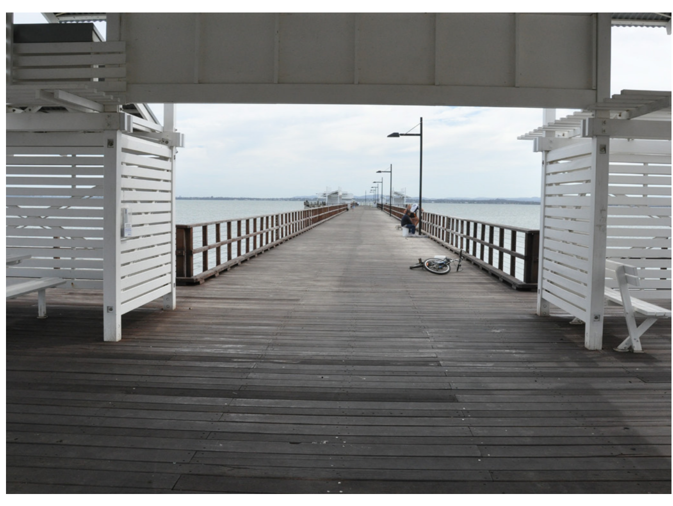
I am nominating again, seeking a fourth term. It is pleasing to see that there are other candidates also prepared to put in the effort.

What I ask of AMA members is to make sure that you actually vote. Typically only 20% of members do vote, and the majority decline to exercise their rights as members.

Naturally, I am also hoping that you will vote for me, to keep representation inside our LMA area. If every member of this LMA votes for the local candidate, that gives a real chance for our LMA to continue to be represented at the highest levels in the AMA.

Don't waste your opportunity to exercise some power as an AMA member. **Vote!**

Wayne HERDY



WOODY POINT JETTY

THIS PRECINCT HAS BEEN PROVIDED FOR YOUR USE AND ENJOYMENT.

MORETON BAY REGIONAL COUNCIL HAS IN PLACE LOCAL LAWS TO ENSURE THE COMFORT AND SAFETY OF ALL USERS.

ALL PERSONS WITHIN THIS PRECINCT SHOULD EXERCISE CAUTION AND USE THE FACILITIES AT THEIR OWN RISK.

THE FOLLOWING ACTIVITIES ARE PROHIBITED ON ANY PART OF THE WOODY POINT JETTY:

1. RIDING OF BICYCLES, SKATES/BOARDS OR SCOOTERS.
2. JUMPING OR DIVING.
3. CAST NETTING 6pm FRIDAY - 6pm SUNDAY AND PUBLIC HOLIDAYS.
4. DEPOSITING OR LEAVING RUBBISH INCLUDING BAIT FISH AND WASTE.
5. TAKING A VEHICLE ONTO THE JETTY WITHOUT A PERMIT.
6. CONSUME ALCOHOL, DISORDERLY CONDUCT.
7. OBSTRUCTING COUNCIL OFFICER IN PERFORMANCE OF THE OFFICER'S DUTIES.

NO RIDING OF BICYCLES

NO SKATES/ BOARDS

NO JUMPING

NO DIVING

NO CAST NETTING 6pm FRI - 6pm SUN & PUBLIC HOLIDAYS

USE RUBBISH BIN

PENALTIES APPLY

AMA Queensland's presence during the state election – Redcliffe and District LMA

During the 2012 Queensland election, AMA Queensland launched our election priorities document entitled - *Seven stitches to fix Queensland Health*.

Seven stitches to fix Queensland Health provides a plan to improve Queensland's health system with common sense, achievable solutions across the seven most troubled areas:

- a disengaged health workforce
- a crippled public hospital system
- an underfunded mental health system
- an unplanned medical education program
- a hospital system disengaged with general practitioners; and
- both the indigenous and rural sectors of our society which are missing out on vital health services.

The centre piece of our broad ranging strategy is a new leadership structure for the state's health system to be known as the Queensland Health Taskforce. This taskforce will be made up of senior politicians – from government and the opposition – departmental staff and most importantly AMA medical practitioners, nurses and other clinicians actively involved in patient care.

For too long the health of Queenslanders has been at the mercy of the three year election cycle and quick fixes, band aid solutions and mitigation strategies to negate negative press have become the norm.

The objective of the new governing body would be to make sure that Queensland Health is well planned strategically for the long term and that the government of the day is providing the right resources and funding.

With the election campaign over now is the time for a real commitment to having doctors at a local level engaged and involved in health planning for their regions. Clinical knowledge is an essential ingredient in the management of a hospital. Clinical policy decisions should be made on the advice of medical practitioners and other practising clinicians.

Further initiatives for general practice needs to be on the agenda as well as long term future plans for the training of the next generation of doctors. Guaranteed funding to meet the expansion of internship numbers and a commitment to quarantine clinical support time must be a key focus to future proof Queensland's health system. The guarantee of funding for intern places should not affect the availability of positions for second and third year junior medical practitioners within hospitals.

There has been much rhetoric about meeting the needs of an ageing and growing population and yet 3000 children referred for paediatric ENT services have no prospect of being helped.

Society must be judged on how it looks after its children and those unable to look after themselves. AMA Queensland will continue to advocate vigorously to the new Government on these issues

To view a copy of the policy document or to receive a comprehensive wrap up of the election refer to our homepage- www.amaq.com.au

Dr Richard Kidd, AMA Queensland President

MEMBERSHIP NOTICE

If you have any topic of interests to share with our membership please email RDMAnews@gmail.com. The article can be either a Clinical or Non Clinical Topic, A Traveller's Tale, an Article for Discussion, Poems, an Advertisement or any combinations. Don't forget to email your articles and graphics to me for inclusion in our monthly RDMA Newsletter.

Woody Point Jetty History

Woody Point is historically significant as the landing spot of Mathew Flinders in 1799. Woody Point is a residential suburb of the Moreton Bay Region at the south-east of the Redcliffe peninsula, approximately 24 kilometers (15 mi) north-northeast of Brisbane formerly a banana plantation. The old Woody Point Jetty was a favourite for weekend trippers but badly in need of replacement. The Marine Safety Queensland advised that works were to be undertaken from a crane barge anchored on the western side of the jetty with additional workboats and debris barges in operation too.

The redevelopment heralds a $9.6m upgrade completed in December 2008 being the last major act of the Redcliffe Shire Council before it merges with Caboolture and Pine River to become the Moreton Regional Council. The redevelopment was funded by the Council and the Queensland 150th Legacy Infrastructure Program.

This replacement jetty will be the third on this site with the first jetty being built between 1881-2 and was famously known as the first such jetty in Queensland. It was an 'L' shaped structure located on the north–western side of the current wharf. The existing Woody Point Jetty with precast and pre-stressed deck units was constructed about 1921 with the original timber deck being replaced in the 1960s. In 1979 significant repairs were undertaken to keep the structure from being condemned. The new jetty is the same length as the old (240 metres) using 10,500 linear metres with a 3.6m wide walkway deck out to the first shade shelter landing. From this point it will then widen to 6m all the way out to the jetty head area.

Along the way there are cantilevered fishing platforms reducing the 'clutter' along the promenade deck and includes two fish cleaning stations on the jetty down lights under the jetty to attract fish at night

An artificial "reef structure" under the jetty head, acts as a habitat and breeding ground for fish.
The old jetty only had one small shade shelter about two thirds of the way along its length and there was no shade shelter at the jetty head. The new jetty will has three shade shelter areas - two on platforms and one on the jetty head. The jetty head itself is built in the shape of a 'Y', to help service vehicles turn. Two small fingers are built as additional fishing platform areas

``The jetty has been part of the local landscape for more than 126 years and the new jetty adds renewed character which will continue to be enjoyed by many generations to come.

People caring for people

RAMSAY HEALTH CARE

Introducing...

Dr Moemen Morris

FRANZCOG

Consulting Gynaecologist & Obstetrician

About Dr Morris

Dr Morris is a graduate of Elminia University & Hospital/Egypt 1989 and holds postgraduate degrees; MRCOG from Royal College of Obestetricians and Gynaecologist /UK; DRCOG from Royal college of Physcians/Ireland and FRANZCOG from Royal Australian and New Zealand College of Obestetricians and Gynaecologists. He came to Australia in 2004 and had been working as Senior registrar in Nambour General Hospital and Royal Brisbane and women Hospital until he is been admitted to the RANZCOG in 2007. Since then he has worked as a full time consultant at Redcliffe hospital, providing an extensive range of obstetrics and gynaecological services, including both conventional and endoscopic surgery. His special interest is in advanced laparscopic surgery.

He is one of the examination board for medical students at University of Queensland and is actively involved in medical education and the training of Resident Medical Officers and Registrars.

When not delivering great gynaecological services, babies and joy to the women of Redcliffe and Caboolture, he occasionally finds time to read good books, listen to music and play a mean game of soccer.

Contact Details
Consulting Rooms at Caboolture Private Hospital
All appointments: (07) 3166 9322
Fax: (07) 3054 0208
McKean Street, Caboolture Qld 4510
Email: drmorris@practicemail.com.au

Caboolture Private Hospital
McKean Street, Caboolture QLD 4510
ph: 07 5495 9400 – fax: 07 5495 9411
www.caboolturepriv ate.com.au

...quality healthcare **close to home!**

CABOOLTURE PRIVATE HOSPITAL

RDMA Meeting 21/02/12

RDMA President Wayne Herdy opened the meeting introducing Adam Dubberley, Novartis sponsor representative who presented Dr Samual Kim topic speaker on New Treatment - COPD Management. Donna O'Sullivan gave an update on Redcliffe Hospital and services. **Clock wise** from top left hand corner: Samural Kim and Wayne Herdy, The current RDMA Executive Team, Samual Kim and Adam Dubberley, Donna O'Sullivan and Pravin Kasan, Ray Collins and Garry Ferris, Chris & Peta McLaren, Amelia Stephens **(New Member)**, Pravin Kasan, Eugene Lim and Premila Balakrishman, Bernard Chan and Mal Mohan and Margaret Smith.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: Wednesday 28th March 2012

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 Wayne Herdy - President RDMA Inc.
7.35pm	Sponsor: IVF Sunshine Coast
7.40pm	Speaker: Dr James Moir Topic: Assessment and Day Surgery Treatment – Pelvic Pain and Bleeding
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: margaret.macpherson@qml.com.au
t: 3049 4444 by Thursday 15th March

AMAQ & FEDERAL BRANCH COUNCILLOR REPORT
North Coast area representative, AMAQ Branch Council,
Queensland Area Representative, AMA Federal Council.
Dr Wayne Herdy

State Politics, Asylum Seekers' Health Care and Traffic Light Front of Package Labelling

With the Queensland state elections right on top of us, it is inevitable that the focus is on the big wish lists. It is superfluous for me to repeat what is being said by the AMAQ President and what is on the AMAQ website. It is equally presumptuous of any writer to anticipate the will of the people, even if the mood and desire for change is overwhelming. The election outcome is going to bring changes – even if the Bligh government defies the polls and is returned, it will be a chastened new government. What we as a profession must be doing is to ensure that the changes that follow in the coming three years are guided by sound evidence and technical advice. With the winds of change on us, we have a duty to our patients to ensure that those winds are soothing and healing, not uncontrolled and destructive. We will have the ear of government, whichever colour, and we must give the best advice we can.

And now for something completely different from State politics.

Every year, the Federal AMA hosts parliamentarians at a dinner in Canberra. The now-traditional Parliamentary dinner is an opportunity to unashamedly lobby whichever pollies are prepared to come for a free dinner, where they are seated with Federal Councillors usually from their home states. At the Parliamentary dinner last year, the AMA President unleashed the beginnings of what has proven to be an ever-growing tide of policy and medical opinion. He stated that the AMA was dedicated to good health care for asylum-seekers. That bare statement has grown progressively into wider policy and some action, not all of it what we wished for.

The narrowest part of the policy is directed at concerns for the health, especially the mental health, of children in custody. Partly fuelled by AMA policy and lobbying, the government has tried to move children out of detention centres. This has had unwanted consequences. Children have been separated from their families. Families have been removed to less prison-like environments, but in locations so remote as to represent a decline in available health resources, not improved access. Clearly, there is a lot left to be done before the AMA ideals are met.

Another area where the AMA has much work yet to be done is in our public health campaign to encourage traffic-light front-of-package labelling to create a simple guide to healthier food choices in the supermarket. People either don't read or don't understand the nutritional analysis written in tiny print on the sides of existing packaging. Although the traffic-light system is now well established in Europe, the Australian government is putting up considerable resistance. They are clearly being influenced by the food manufacturers, who want minimal interference between their product and their market. The initial proposal for a traffic-light food labelling system in Australia was planned to be voluntary, even though we knew that those who manufacture unhealthy foods would simply not join a voluntary system that brands their products as undesirable. Even this very lenient provision has not met with the approval of government – as I said, we have a lot more work to be done.

Wayne HERDY
AMAQ & Federal Branch Councillor

REDCLIFFE'S NEW 'SUPER' MOVES FAST IN ACTING ON PROBLEMS

• Redcliffe Hospital Superintendent Dr Steve Buckland at his desk . . . moving fast to identify areas that need attention.

Redcliffe Hospital's new superintendent, Dr Steve Buckland, has moved quickly to establish strong contacts with the medical profession as well as identifying areas where remedial action is needed.

Dr Buckland, reflecting on his first 100 days in office since joining the hospital on December 2 last year, concedes he has found a lot of things "not the way I expected," but he is confident a lot of improvements can be made.

One of his first actions was to disband - with appropriate help - the Visiting Medical Officers association and replace it with a Specialist Staff Association which will establish a Medical Advisory Committee.

Dr Brian Elliott has been elected president of the new association and has already established lines of communication with Dr Buckland.

President of the Redcliffe and Districts Local Medical Association, Dr Kerry Garske, has also held talks with Dr Buckland and assured him of total support for his moves to provide improved hospital services and facilities.

Dr Buckland, 38 on March 2, came to Redcliffe from the Ipswich Hospital where he was Deputy Medical Superintendent.

A Queensland University graduate in 1976 with the MBBS degree, he went to the United Kingdom in 1984 and gained a diploma in Aviation Medicine.

The first 100 days in office

This was followed in 1985 by a Fellowship to the Australian College of Occupational Medicine and in 1989, he completed the University of New South Wales course to become a Master of Health Administration.

His views of the needs of Redcliffe Hospital were spelled out in the Towards 2000 report which has been prepared for the Hospital Board and the Department of Health as his first major under taking.

Dr Buckland is quick to stress that the 21 page report is only a working document at this stage and that it will be a much more comprehensive publication when the full report is completed.

"It is very superficial at this stage but it has become obvious that the hospital has been unable to provide full services required by the community since 1981," he told the LMA.

"There is no doubt we need Stage 2 immediately and it is a much more important option than simply building another hospital at Caboolture," he said.

Dr Buckland has given an assurance that he will attend LMA meetings when time permits but he admitted his spare time was usually devoted to slipping away to a property near Nanango wher there were no telephones and he could watch the world go by.

"When I came from Ipswich, I knew what to expect in a provincial hospital with staff and equipment," he said.

"But I did expect the hospital to have a broader coverage of services and I expected it to meet the needs of the community better than it does.

"It runs of goodwill and it has achieved what it has through goodwill and the capabilities of the staff.

"It is the best staff I've worked with but there is a huge gap between what the hospital does and what is expected of it," Dr Buckland said.

• OPINION Flegg worthy of support in Federal poll

The Federal election on March 24 gives the people of Petrie a chance to elect a medical doctor who has a close and intimate working knowledge of health care in this country.

Dr Bruce Flegg, the endorsed Liberal candidate, deserves the support of the medical profession from all those entitled to vote in Petrie, so that we may have a voice in the forum where we urgently need it - the floor of Parliament in Canberra.

It is obvious the Federal Labor Government is determined to press on towards the ultimate nationalisation of medicine in this country and it will take a strong, knowledgeable representative like Bruce Flegg to be the voice of those who know what it will mean to doctors and health care.

MEDICARE REALITIES

Dr Flegg has shown he has a grasp of the realities of what is happening to Medicare and the Vocational Register for General Practitioners.

We must give him the opportunity to ensure Parliament is made away of why these errors must be corrected, and quickly.

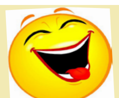
What's The Newest **Private Hospital Facility** On The Northside?

NORTH LAKES
—DAY HOSPITAL—

The North Lakes Day Hospital is the new centre of medicine in one of Australia's fastest-growing precincts and will feature Endoscopy, IVF, Orthopaedics, General Surgery, and Ophthalmology. Located in the North Lakes Medical Precinct, neighbours include QDI, QML, Queensland Health, OzCare and Lakelands Medical Centre.

www.montserrat.com.au

Interesting Tidbits NATTY MOMENTS:



OLD AGE – SERENITY

Just before the funeral services, the undertaker came up to the very elderly widow and asked, 'How old was your husband?' '98,' she replied. 'Two years older than me' 'So you' re 96,' the undertaker commented. She responded, 'Hardly worth going home, is it?

Reporters interviewing a 104-year-old woman: 'And what do you think is the best thing about being 104?' the reporter asked. She simply replied, 'No peer pressure'.

The nice thing about being senile is: 'You can hide your own Easter eggs' .

I've sure gotten old! 'I've had two bypass surgeries, a hip replacement, new knees, fought prostate cancer and diabetes. I'm half blind. Can't hear anything quieter than a jet engine. Take 40 different medications that make me dizzy, winded, and subject to blackouts. Have bouts with dementia. Have poor circulation. Hardly feel my hands and feet anymore. Can't remember if I'm 85 or 92. Have lost all my friends. But, thank God, I still have my driver's license.

I feel like my body has gotten totally out of shape, So I got my doctor' s permission to Join a fitness club and start exercising. I decided to take an aerobics class for seniors. I bent, twisted, gyrated, jumped up and down, and perspired for an hour. But, by the time I got my leotards on, the class was over.

My memory's not as sharp as it used to be. Also, my memory's not as sharp as it used to be.

Know how to prevent sagging? Just eat till the wrinkles fill out.

It's scary when you start making the same noises as your coffee maker.

These days about half the stuff in my shopping cart says, ' For fast relief.'

THE SENILITY PRAYER
Grant me the senility to forget the people I never liked anyway. The good fortune to run into the ones I do, and the eyesight to tell the difference.

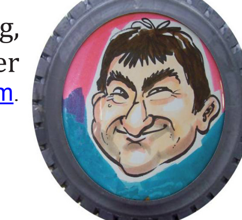
Always Remember This: You don' t stop laughing because you grow old, you grow old because you stop laughing!!

Not that any of us are old!

Monash IVF
monash ivf
life starts here
Due early 2012
www.monashivf.com

North Lakes
North Lakes Day Hospital
7 Endeavour Blvd
North Lakes 4509
T (07) 3345 4455

Safe motoring,
Doctor Clive Fraser
doctorclivefraser@hotmail.com.



Holden VN Commodore "Another One Bites The Dust"

In 1990 Holden's VN Commodore was Australia's most popular new car. Though it was powered by an old Buick V6 from a front-wheel drive US model, it still managed to be awarded the Wheel's Car Of The Year award against an inferior EA Falcon rival.

For $19,990 plus on road costs it was great value and in the second-hand market the VN became the preferred chariot for boy-racers who worshipped Peter Brock's three previous Commodore Bathurst wins in 1980,1982 and 1984.

Unimpressed by street-racers, in 1990 my father traded in his much-loved Holden Camira on a VN Commodore and in the past 22 years he has covered only 70,000 kilometres in what has been a mostly reliable, simple to fix and cheap to run vehicle.

There were some features of the VN Commodore which you learn to love, like the coarseness of the V6 motor which redeems itself by taking off from the lights like a V8. There was 125 Kw from a theoretical 4,800 rpm, but the harshness of the engine wouldn't let you test those revs. The engine's strong point was the whopping 288 Nm of torque peaking at 3,200 rpm.

In the past 14 years Commodore sales in Australia have dropped by 60% from a very healthy 94,000 in 1998 to only 40,000 last year and our most popular new car now is the much-lauded Mazda 3.

At $23,690 drive-away for a 5 speed auto Mazda 3 it's easy to see why they sell so well and I doubt that my father will buy another full-size car such as the current model VE Commodore. But his old VN's wiring is 22 years old and unfortunately the car has stopped twice unexpectedly in traffic with electrical problems.

Those breakdowns have been fixed, but no amount of re-assurance about the repairs will restore my father's confidence in the car and its time to trade it in and move on. If you allow for inflation the VN Commodore would cost about $39,000 in today's dollars, significantly more than Holden's current model VE Series 2.

Holden have been selling 2011 plated VE's with a limited edition Equipe package for $34,990 drive-away.

Back in 1990 the VN made do with 14 inch steel wheels and air conditioning was an option.

In 2011the VE Equipe has 18 inch alloys and dual climate control. Leather seats, a reversing camera and a six speed automatic transmission are but a few of the pieces of fruit in today's car.

And whilst the VE Series 2 Equipe's pricing seemed very keen when first advertised, GM are now offering another $750 bonus on genuine accessories. But I'm thinking that my father doesn't really need another large car and that he'll save about $11,000 and buy a Mazda 3, just like almost everyone else.

1990 VN Commodore Executive vs 2011 VE Commodore Equipe

Specifications:

	1990 VN Commodore	*2011 VE Commodore*
Body	*Executive Sedan*	*Equipe Sedan*
Engine	*3.8 litre V6*	*3.0 litre V6 DOHC VVT*
Power	*125 kW @ 4,800 rpm*	*190 kW @ 6,700 rpm*
Compression ratio	*8.5:1*	*11.7:1*
Torque	*288 Nm @ 3,200 rpm*	*290 Nm @ 2,400 rpm*
Transmission	*4 speed auto*	*6 speed auto*
Kerb weight	*1335 kg*	*1648 kg*
Length	*4850 mm*	*4903 mm*
Economy	*9.7 l/100 km*	*9.1 l/100 km*
Air conditioning	*Optional*	*STD climate-controlled*
Airbags	*Nil*	*Six*
Price	*$19,990 + ORC*	*$34,990 drive-away*

Safe motoring,
Doctor Clive Fraser

Caboolture Private Hospital

People caring for people

Medical consultants/specialists' listing

Hospital/general enquiries:
07 5495 9400
Hospital facsimile T: 07 5494 9411
McKean Street, Caboolture QLD 4510

DENTAL SURGERY

Richard French	5495 1270
Sean Keren	3410 1610

ENT SURGERY

Brian O'Reilly	5444 4755

GASTROENTEROLOGY

Nicholas Anticich	5498 9077
Agus Brotodihardjo	5498 9077
Andrew Hallam	5498 9077
Andrew Lee	5498 9077
Sylvia Vigh	5498 9077
Marnie Wood	5498 9077

GENERAL SURGERY

William Braun	3283 4200
Jonathan Davies	3283 4200
Christopher Lusink	3216 4590
Hugh McGregor	3283 4200
Daniel Mehanna	5495 9440
Philip Scarlett	3881 1234
Boris Strekozov	5495 9440

GYNAECOLOGY

Amanda Evans	5495 9440
Moemen Morris	3166 9322
Mahilal Ratnapala	5495 9440

HAEMATOLOGY

Mark Bentley	3834 6489

INTERNAL MEDICINE

Robert Hynes	3883 1094
Jai Ram	5498 9077

ONCOLOGY

Rick Abraham	3834 6489

ORAL & MAXILLOFACIAL SURGERY

Barbara Woodhouse	3839 4717

ORTHOPAEDICS

Ross Boulton	3283 2244
Abdul Chaudhry	3339 1515
David Chin	3871 3330
Michael Fleming	3284 6633
Anthony Houston	3889 5577

PALLIATIVE MEDICINE

Grant Cameron	5499 3339

PLASTIC SURGERY

David Chin	3871 3330
Timothy Finucan	3883 2277

THORACIC & SLEEP MEDICINE

Sean Tolhurst	3324 1699

UROLOGY

Patrick Dunne	3326 3683
Jamie Reynolds	3889 4107

VASCULAR SURGERY

Glenn Sproles	3832 4636

www.cabooltureprivate.com.au

Why travel to Brisbane when you can have safe, professional care in a local, modern facility with the Specialist of your choice.

Caboolture Private Hospital's Centre of Excellence for day & short stay surgery is your natural choice. Just ask your GP to refer you to one of our admitting Specialists…then, when you see your Specialist, ask if your procedure can be booked at Caboolture Private.

Microscopic Colitis

Author
Dr Sam Islam
MBBS, FRACP, PhD.

Microscopic colitis (MC) is now increasingly recognised as a cause of painless, non-bloody watery diarrhoea mainly in the elderly. In a large cohort of histologically confirmed MC about half of them met symptom based criteria of IBS (irritable bowel syndrome) such as abdominal pains accompanied with altered bowel habits and form of stool, bloating with relief with defaecation or passage of flatus, and negative colonoscopic findings) indicating a significant symptomatic overlap between these 2 conditions. It is characterised by normal or near-normal looking colonic mucosa but with characteristic histological changes in biopsy samples taken from both sides of the colon. 2 principal varieties are known- Lymphocytic colitis (LC) and Collagenous colitis (CC) having incidences varying between 4- 6/100,000 population per year with peak incidence at 60-70 years of age with a slightly higher female predominance. These entities have been properly described relatively recently, CC in 1976 and LC in 1989.

Careful histopathological evaluation and awareness of its numerous associations (especially with drugs and celiac disease) and mimics will lead to the correct diagnosis. The etiology of microscopic colitis remains enigmatic and is multifactorial with different elements being more influential in different individuals. Treatment includes antidiarrheal agents and anti-inflammatory drugs (including steroids). The purpose of this article is to provide some clarity on the entity, discuss the multitude of conditions that can occur synchronously or metachronously with microscopic colitis and their role in this condition, provide a brief review of the pathological aspects of the disease and to briefly discuss treatment trends.

CLINICAL PRESENTATIONS

The onset of disease may be sudden mimicking infectious diarrhoea. The clinical features of CC and LC are similar- chronic and recurrent painless watery diarrhoea often with nocturnal presence. Diffuse abdominal pain and significant weight loss with fatigue, faecal urgency or incontinence are other less common features. All the above may have a significant negative impact on the quality of life. Although the clinical course is largely benign it can be relapsing. Few reports of colonic perforation have been reported but no increased risk of colon cancer is noted. Temporal association with autoimmune diseases are widely known (in as many as 40-50%) namely thyroid disease, celiac disease, diabetes mellitus, rheumatoid arthritis, etc. MC should be suspected in patients with celiac disease who are not responding to gluten-free diet.

AETIO-PATHOGENESIS

The cause of MC are likely multi-factorial and is largely unknown. They may represent specific mucosal response in predisposed individuals to various noxious luminal agents. LC and CC are likely to be related but are separate entities with significant common features.

GENETICS

Familial occurrence of CC has been reported but the role of genetic factors remain largely unknown. HLA studies have shown an association between MC and HLA-DQ2 or DQ1/3 and HLA-DR3-DQ2 haplotypes irrespective of concomitant celiac disease. No association with NOD2/CARD15 (indicator of strong association with fibrostenosing ileal Crohn's disease) polymorphisms and susceptibility to CC have been found.

DRUG-INDUCED MC

NSAIDs are among the drugs often implicated in the pathogenesis of MC while the other known associates are acarbose, aspirin, lansoprazole, ranitidine, sertraline, paroxetine, ticlopidine, carbamazepine, simvastatin, etc. Infections have been suspected as well. Associations with *Campilobacter jejuni, Yersinia enterocolitic, Clostridium difficile* have been reported on occasions.

NITRIC OXIDE

Colonic NO production is greatly increased in active MC caused by upregulation of inducible nitric oxide synthese (iNOS) in the colonic epithelium. The level of NO are correlated to clinical and histological disease

Continued: Page 16

MEMBERSHIP NOTICE

If you have any topic of interests to share with our membership please email RDMAnews@gmail.com. The article can be either a Clinical or Non Clinical Topic, A Traveller's Tale, an Article for Discussion, Poems, an Advertisement or any combinations. Don't forget to email your articles and graphics to me for inclusion in our monthly RDMA Newsletter ,

Workplace bullying

Bullying happens in many different situations, including in the workplace. This is important to know if you have a part-time job on the weekends or after school.

When bullying happens in the workplace, it is often done by someone in a position of power, such as a boss, manager, supervisor, or someone who has been at the workplace longer or someone who is simply older than you. Sometimes, a person can be bullied by some of the other employees they work with.

Remember, just because your supervisor tells you to do something you dont like, this doesn't necessarily make it bullying.

Workplace bullying can take different forms. For example:

- an employee repeatedly being shouted at, insulted or threatened by their boss;
- an employee repeatedly being disciplined or punished without reason;
- an employee repeatedly being given difficult tasks without sufficient time to complete them;
- an employee repeatedly being teased, or ridiculed by fellow workers; or
- an employee repeatedly being denied the same rights and privileges as other workers.

It is your employer's responsibility to prevent and stop bullying in the workplace, regardless of who is doing the bullying. Everyone has the right to work and be free from bullying, harassment, discrimination, and violence.

If you are being bullied at work you should:

- record details of the bullying incidents;
- check your employer's policies about how to report bullying in your workplace;
- tell your supervisor or health and safety representative about the bullying;
- contact your union representative; and
- contact WorkCover.

More information and advice

People who have been seriously bullied can become depressed and develop mental health problems. If you are worried that this may be happening to you, make an appointment with your doctor straight away to talk about it.

If you feel suicidal because of bullying, talk to a trusted adult about it straight away. The Kids Helpline is available on 1800 55 1800 or www.kidshelp.com.au .

Some useful sources of information on bullying, cyber-bullying, or workplace bullying include:

- Your GP
- Lifeline: 131 114 or www.lifeline.org.au
- Youth beyondblue: www.youthbeyondblue.com
- Reach Out!: http://au.reachout.com/
- Inspire Foundation: www.inspire.org.au
- Headspace: www.headspace.org.au
- The Line: www.theline.gov.au
- National Centre Against Bullying: www.ncab.org.au
- Bullying No Way: www.bullyingnoway.com.au
- South Australia's Children, youth and women's health service: www.cyh.com
- National Children's and Youth Law Centre: www.lawstuff.org.au
- Cybersmart Kids Online: www.cybersmart.gov.au
- NetAlert: www.netalert.com.au

Your local GP:

AMA

42 Macquarie Street Barton ACT 2600
Telephone: 02 6270 5400 Facsimile: 02 6270 5499
www.ama.com.au

BULLYING

What you need to know

AMA

BULLYING

What is bullying?

Bullying occurs when a person, or group of people, repeatedly says or does things to someone that are negative and make them upset or frightened. A 'one-off' argument is not bullying. Bullying can be common. One quarter of Australian school children report that they have been bullied.

Examples of bullying can include:

- repeated teasing, name calling or threats;
- being physically rough;
- being continually excluded from things.

Sometimes bullying is deliberate, and intended to make a person upset. But it can sometimes still be bullying if someone repeatedly acts in ways to make a person upset or frightened, even if it is not deliberate.

I am being bullied. What should I do?

Being bullied can be very upsetting. It can feel like you have no one to talk to about it. But it is important to remember that you are not alone. There are people you can tell, and things you can do. You can:

- ignore or stay away from the bully; or
- tell the bully that he or she is bullying you and that you want them to stop.

It is important to stay calm and not to retaliate against a bully.

Even when you try to stop someone from bullying you, sometimes they will continue. If this happens, you need to tell an adult you trust. This could be a parent, teacher, school counsellor, or your doctor. This is not 'dobbing'. An adult who you trust can help with advice on how to deal with the bullying. They can also take action to make sure the bullying stops.

In some cases, bullying can involve physical violence. Physical violence is wrong. If someone is physically violent to you or your friends, go to a safe place as quickly as possible and then tell a trusted adult or the police as soon as possible.

In some cases, bullying can involve physical violence. Physical violence is wrong. If someone is physically violent to you or your friends, go to a safe place as quickly as possible and then tell a trusted adult or the police as soon as possible.

Cyber-bullying

Cyber-bullying is bullying that happens online (eg., email, Facebook, MySpace), or through mobile phones. Cyber-bullying can include repeated behaviour like:

- sending threatening text messages to a victim;
- sending untrue, embarassing or hurtful information about a victim in an email, sms or mms message to others, or posting it to a blog, or online site;
- emailing or posting altered images of a victim that cause them humiliation;
- sending a virus or spyware to infect a victim's computer;
- taking a victim's online identity, pretending to be them, and damaging their reputation.

You can try to prevent cyber-bullying by only giving your mobile phone number, email address, and online contact details to people you completely trust. Also, only allow your real friends to be your friends on Facebook.

If you are being cyber-bullied, you can block or ignore the sender. An adult you trust can also help you contact your mobile phone or internet service provider. Online messages and text messages can be traced, and people who keep sending bullying messages can be blocked from using their phone or internet services. If cyber-bullying is an ongoing problem for you, it is important to tell a trusted adult.

Am I a bully? Have I helped to bully someone?

Everyone is capable of bullying. Some people may have engaged in bullying without meaning to and without knowing. Sometimes people say they are 'only joking' or 'mucking around'. They forget that other people may not feel the same way, even if they don't seem to be upset at the time.

Have you ever repeatedly:

- called classmates or other students names or 'teased' them?
- been physically 'rough' with classmates and friends?
- made fun of how someone looks?
- intentionally left someone out of an activity, or purposely ignored them? or
- spread rumours about someone?

If you answered yes to any of these questions, it is possible that you may have engaged in bullying. You do not have to be friends with everyone, but you should try to treat everyone with respect.

activity. Treatment with budesonide, in contrast to placebo has resulted in significant reduction of iNOS mRNA that is correlated with clinical and histological improvement.

DIAGNOSIS

Laboratory tests are unhelpful with only variable but modest rise in C-reactive protein, erythrocyte sedimentation rate, or mild anaemia are found. Faecal cultures and microscopy are non-diagnostic with a mild rise in calprotectin at times. The diagnosis of MC is based on clinico-pathological correlation- i.e. clinical features backed by histological changes in the colonic epithelium as revealed by colonoscopic biopsy specimens. In CC thickening of the subepithelial collagen layer is seen together with a mononuclear cell infiltrate in the laminal propia and epithelial cell damage with an occasional increase of intraepithelial lymphocytes. The thickened subepithelial collagen layer is ≥10μm in contrast to the normal thickness of <3μm. These changes are more prominent in the biopsies obtained from the proximal colon and may be absent in those obtained from the left colon. The diagnosis of LC is based on increased intra-epithelial lymphocytes (≥20/100 surface epithelial cells) along with surface epithelial cell damage and infiltration of lymphocytes and plasma cells in the lamina propria with intact collagen layer.

TREATMENT

A detailed history is very helpful. Use of irritants foods, those which are known to hurry the bowel like caffeine, alcohol, strong spices are to be avoided and low residue diet instituted. Individual food sensitivities must be taken in to account along with drug therapy.

Drug therapy consists of Budesonide 9mg daily for 6-8 weeks (number needed to treat is 2 pts) is superior to placebo as is conventional reducing dose prednisolone starting at 40-50mg/d. Clinical response is usually quick but relapse occurs equally promptly upon cessation of the short-term therapy. Tapering the dose to 3-6mg/d continued to 6 months has achieved better long term response of around 83%. Histological response was seen in 50% compared to 15% for placebo. However, 6 months of maintained therapy backed by histological response failed to keep the disease under control upon withdrawal of therapy with median time to relapse of 40 days. Prednisolone produce less prompt response and has more frequent side-effects but head to head comparative studies with budesonide are infrequent.

Antidiarrhoeal agents like loperamide or lomotil are effective as long as they are taken on regular basis but lacks disease-modifying potentials. Institution of low residue non-irritant diet is a commonsense approach. Other agents that have been tried are Bismuth subcitrate, Sulphasalazine or Mesalazine. Bismuth was effective in several trials but the agent is not widely available in Australia. Masalazine has been found to be effective in conjunction with Cholestyramine, however efficacy of either agent alone is not widely studied.

Antibiotics (metronidazole, erythromycin) have not shown much promise. Immunosuppressive agents have been triad in steroid resistant cases with modest efficacy. 6-MP or azathioprine (dose 1-2mg/kg/d respectively) is much better than Methotrexate (dose 5-25mg/wk) in inducing remission although both have been modest. In resistant cases one may try gluten-free diet, and review diagnosis to consider celiac disease, hyperthyroidism, carcinoid syndrome, VIPoma and continued NSAID use. Rarely surgical therapy with faecal stream diversion through ileostomy , sigmoidostomy, colectomy have been tried with success in severe refractory cases.

PROGNOSIS

Long term prognosis of MC is benign with most settling down (in 70% of cases) in 3.5 years from diagnosis. A few would need to be treated with low dose corticosteroids or other ongoing therapies. No increase of colorectal-cancer or incidence of IBD has been documented from 2-12 years of follow-up. Relapse seems to be common after budesonide therapy. The long term prognosis is however good with low risk of complications. In a series with prolonged (5-16yrs) follow-up, the course was chronic intermittent in 85%, chronic continuous in 13%.

CONCLUSION

The entity of 'microscopic colitis' is being diagnosed with increasing frequency and is a well-established clinicopathological diagnosis that is underpinned by a triad of watery diarrhea, normal results on colonoscopy and characteristic microscopic findings. MC is thus a common cause of painless, non-bloody diarrhoea mainly affecting the elderly. It may need prolonged and varied drug trial as no single agent is uniformly effective or safe. It has potential to adversely affect the quality of life. Diagnosis is clinico-pathological and treatment is non-specific leaving considerable room for individualising therapy.

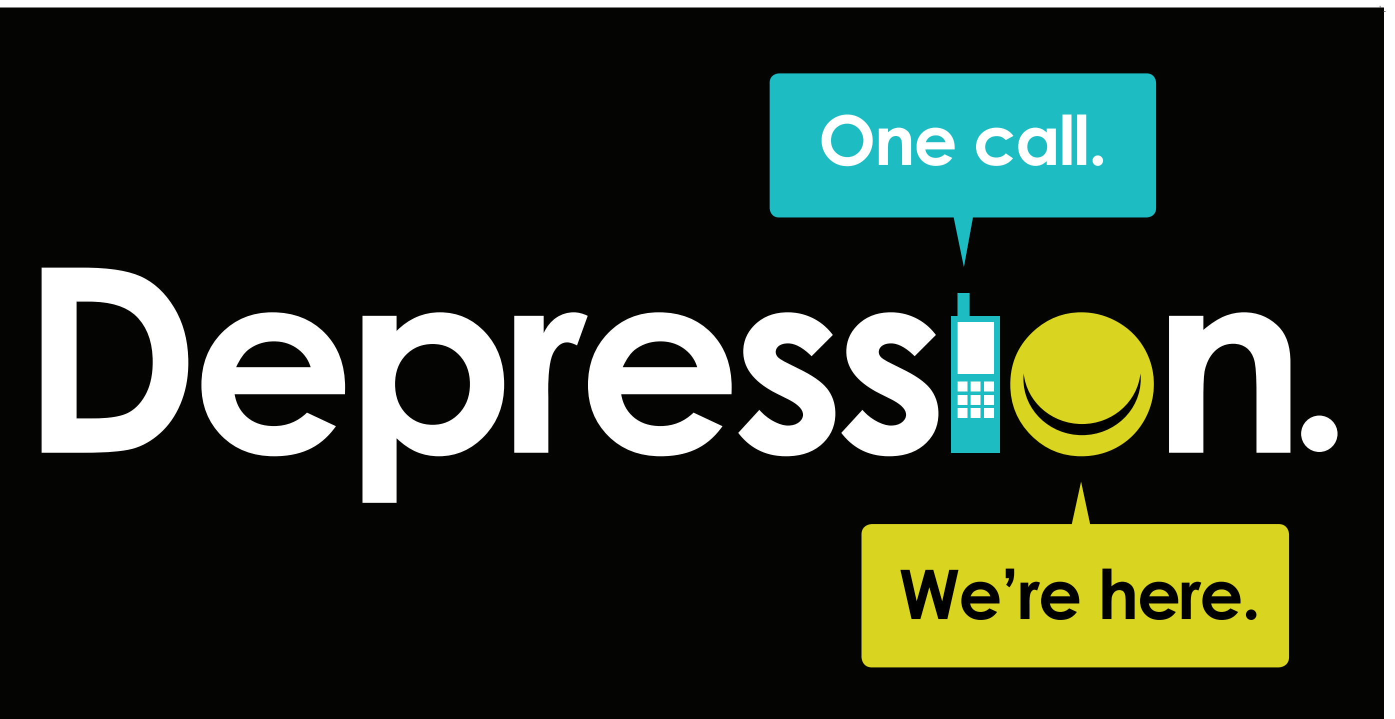
Further reading:

1. Tysk C, Bohr J, Nyhlin N, et al. Diagnosis and management of microscopic colitis.
World J Gastroen terol 2008; 14(48): 7280-7288.

2. Datta I, Brar SS, Andrews CN, et al. Microscopic colitis: a review for the surgical endoscopist.
Can J Surg 2008; 52 (5): E167-172.

Author:

Dr Sam Islam MBBS, FRACP, PhD.
Gastroenterologist
Montserrat Day Hospital
North Lakes Day Hospital
Endeavour Boulevard.



3881 7222

Don't miss out on Education Points!

Enrol in the Surgical Skin Audit

- **Assess** the accuracy of your identification, detection, and histological and provisional diagnoses of skin lesion cases
- **Compare** your case results with other doctors
- **Receive** graphical reports, statistics and data on a monthly basis
- **Earn** 40 RACGP QI&CPD Category 1 points and/or 30 ACRRM PRPD points

For further information, please phone Margaret MacPherson, Medical Liaison Officer on (07) 3049 4429.

DOCTOR REQUIRED

for

LEASE OF MEDICAL CENTRE IN REDCLIFFE

Phone

Mobile: 0409639918

February 2012

MEMBERSHIP NOTICE

If you have any topic of interests to share with our membership please email RDMAnews@gmail.com. The article can be either a Clinical or Non Clinical Topic, A Traveller's Tale, an Article for Discussion, Poems, an Advertisement or any combinations. Don't forget to email your articles and graphics to me for inclusion in our monthly RDMA Newsletter ,

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 TAKES ACTION TO PREVENT BULLYING

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

In recognition of the National Day of Action Against Bullying and Violence, the AMA today released two new practical tools to help raise awareness of child and adolescent bullying and its health effects and to provide sound advice about who people can turn to for help. The Minister for School Education, Early Childhood and Youth, The Hon Peter Garrett MP, and AMA President, Dr Steve Hambleton, launched the two new AMA brochures at Mascot Public School in Sydney this morning.

A brochure for older children and adolescents, Bullying: What you need to know, explains what bullying is, provides specific information on cyber bullying, and gives advice about how to deal with being bullied and how to identify bullying behaviours. A second brochure, AMA Guidance for Doctors on Childhood Bullying, contains a childhood bullying fact sheet for use by medical professionals who are interested to know more about childhood bullying and its health impacts.

Minister Garrett said that all school students need information and encouragement to work collectively towards reducing the incidence of bullying in Australian schools. "It's been estimated that one in four school students are bullied every few weeks or more," the Minister said. "Schools have an important role to play in the prevention of bullying and many schools are making concerted efforts to prevent and address the problem. "There can never be too much information to help prevent bullying and I am sure that schools and families will welcome the contribution of the AMA in the ongoing campaign to stamp out bullying and its harmful effects," the Minister said.

Dr Hambleton said that young people might be reluctant to disclose that they are being affected by bullying, especially online or through social networking sites, and that is why the AMA is promoting doctors as a source of safe and reliable information and advice about bullying. "Doctors are a trusted and confidential source of information in the community," Dr Hambleton said. "We want young people to know that they can talk about bullying with their family doctor, and we want to make sure that doctors are equipped with comprehensive information and advice to help their young patients. "The physical and mental health consequences for people who are bullied are serious. Victims of bullying can become traumatised, anxious and seriously depressed, and sometimes these problems can continue through to adulthood.

"The AMA congratulates the Government and the Minister for taking a strong stand against bullying," Dr Hambleton said.
Background:

- Research from the Murdoch Children's Research Institute found students who were bullied had almost a two-fold increase in the likelihood of depressive symptoms the following year;
- While schools can work towards the prevention of face to face bullying, cyber bullying that happens outside the school setting is an increasing problem;
- Cyber bullying can take a number of forms including sending threatening text messages or emails; circulating untrue, embarrassing or hurtful information by sms, email or social networking sites; emailing or posting altered images; sending a virus or spy ware or taking on someone's identity online and damaging their reputation;
- Cyber bullying can involve a wide audience, the person being bullied may have little or no respite from online bullying, and the person or people doing the bullying may have some element of anonymity;
- According to a January 2012 study by the Ipsos Social Research Institute, of the 24 countries surveyed Australia was the worst place for bullying over social networks, and the fifth for bullying online (this means that Australians were more likely to bully on social network sites like Facebook and Twitter than in chat rooms or on mobile phones);
- A survey conducted by BoysTown found that the most prevalent forms of cyber bullying were name calling (80 per cent), abusive comments (67 per cent), and spreading rumours (66 per cent);
- Recent research suggests that 10 to 15 per cent of students have experienced cyber bullying more than once (experience from the US and the UK suggests that this could increase to 30 to 40 per cent);
- In a survey conducted for the recent Government Inquiry into Cyber Safety, 8.8 per cent of survey participants (15,592) admitted that they had cyber bullied someone else. Of those, 66 per cent reported that they had also been the victim of cyber bullying;
- Research commissioned by Microsoft in 2008 found that 83 per cent of parents did not know what to do if a child was being cyber bullied, and two out of three were unsure of the best ways to help their children; and
- Facebook has introduced tools that aim to reduce cyber bullying (and identify those people who may be at risk of suicide).

Schools and medical practices can obtain hard copies of the brochures by contacting the Federal AMA at mrickard@ama.com.au

Bullying: What you need to know is available electronically at http://ama.com.au/youthhealth/bullying

AMA Guidance for Doctors on Childhood Bullying is available electronically at http://ama.com.au/youthhealth/bullying-guidance-for-doctors

16 March 2012

CONTACT:
John Flannery Phone: 02 6270 5477 / 0419 494 761
Kirsty Waterford Phone: 02 6270 5464 / 0427 209 753

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

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION MEMBERSHIP

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

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

Meeting dates are in the date claimers on page 4
COST for non-members:
$30 for doctor, non-member

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION MEMBERSHIP

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

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

Meeting dates are in the date claimers on page 4
COST for non-members:
$30 for doctor, non-member

CHANGES TO CLASSIFIEDS

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

Classifieds will be published for a maximum of three placements.

Classifieds are not to be used as advertisements.

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

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription due for the period: 1st July 2011 to 30th June 2012

Dear Doctor

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

As this is now June 2011 your subscription to cover until the 30th June 2012 will be $100. **Doctors-in-training and retired doctors are invited to join at no cost.** This subscription not only entitles you to ten (10) dinner meetings but also to a monthly magazine. Contributions and suggestions on topics and/ or speakers are very welcome.

Please can you endeavour to pay your subs by internet banking as it is so much easier for all concerned, saving you writing cheques and us having to bank them? You will receive your receipt by email if you supply your email address to me on **GJS2@Narangba-Medical.com.au.**

Yours sincerely

Dr Peter Stephenson
Treasurer

REDCLIFFE & DISTRICT LOCAL MEDICAL ASSOCIATION INC.

ABN 88 637 858 491

Note: **Two Medical Practitioners from the One Family Qualify for a $25 Discount each**

Tick box **1. One Member ($100) 2. Two Family Members ($150)** **(Complete BOTH sets of details)**

3. Doctors-in-training and retired doctors: Free

1. Dr. ______________________________ ________________________________
(First Name) (Surname)

2. Dr. ______________________________ ________________________________
(First Name) (Surname)

1. *EMAIL ADDRESS:* ___________________________@_______________________

2. *EMAIL ADDRESS:* ___________________________@_______________________

Practice Address: ____ Post Code: _______

Phone: ___________________________ Fax: _____________________

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

METHODS OF PAYMENT:

1. PREFERED **INTERNET BANKING**
2. PAYMENT BY DEPOSIT SLIP: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. ENCLOSED PAYMENT: (Note: Member Subscription Form on website for you to type directly into and email)

i) **Complete form & return: c/-QML or Redcliffe & District Medical Assoc Inc. P O Box 223 Redcliffe 4020**

ii) **Or by email to** GJS2@Narangba-Medical.com.au

Where We Live And Work

Woody Point