RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
MARCH 2013

Wamuran

See Wamuran in our historical article in our regular Where We Live And Work segments page 3 and 20.

President's Message . Dr WAYNE HERDY

Is it not curious that a payroll system that should have cost $6M on the contract price blew out to close to $1B and still counting – and it still doesn't work? The judge-led enquiry to sort out the blame (but not solve the problem) is going to cost more than the original contract price! A new payroll system was necessary – the alternative was a decrepit pay system creaking at the seams (but nevertheless functional – barely).

The Newman razor gang has cleared the decks of some 14,000 jobs in the Queensland public service. A saving of close to $10B each year – unless many of those jobs get outsourced to the private sector. The shaving was necessary – the alternative was a bankrupt State within a decade.

The cause was a massive public service self-propagating under a series of governments that could not control their administrative arm. Queensland Health loses millions to a Pacific Island "Prince" – who eluded the auditors for years despite the magnitude of the takings.

The former Bligh government lost favour with its own trade union power base when it started to sell public assets to pay the bills. The Newman government is not all that far behind when it comes to selling off the family jewels. Governments deal with huge sums of money every day. As we small-fry workers juggle our budget, we know that small parcels of money are always slipping between our fingers. The price we pay for our fiscal inefficiencies is shorter holidays and smaller cars. But when big government lets billions slip between their fingers until the cash flow gets critical, the price we pay is proportional – we cannot pay for essential public infrastructure.

Queensland needs maybe five new hospitals today, and in our own back yard neither the Federal nor the State government can properly fund basic health policy. The Redcliffe GP Super Clinic, the LHHN, and the Medicare "Local" are all struggling with insufficient cash to achieve their roles.

When it comes to past waste of public moneys, the water is well and truly under the bridge. As a medical profession, our task for the future is to be alert to ongoing waste and mismanagement to reduce the chance that the profligate mis-spending of past decades will not result in us having to work our way around inadequate hospitals and other public health facilities.

Wayne Herdy
RDMA President

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

2013 MEETING DATE CLAIMERS:

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

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Tuesday February 26th
Wednesday March 27th
Tuesday April 30th
Wednesday May 29th
Tuesday June 25th
Wednesday July 31st

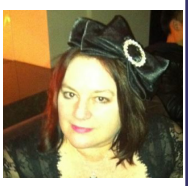
Annual General Meeting
Tuesday August 27th

Wednesday September 18th
Tuesday October 29th

End of Year Networking Function
Friday November 29th

CONTACTS:

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



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APRIL NEWSLETTER 2013

The 15th April 2013 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:

Wamuran, Queensland

It was common in early settlements for an aboriginal to take the surname of his employer. Such was the case for Jackie Delaney, who was one of the last aboriginal people in the Wamuran district and who worked for Joe Delaney, a landholder with acreage extending from Upper Burpengary Creek (Stoney Creek) and stretching to the Redcliffe Peninsula. Jackie's aboriginal tribesmen knew him as Menvil Wanmuarn and he was given the title 'King of Stoney Creek'. His wife Kitty was the last aboriginal woman in the area and the daughter of Queen Beauty. The township's name of Wamuran was derived from Jackie's tribal surname of Wanmuarn.

Farming in Wamuran

Wamuran is a beautiful area with rich farm land, the D'Aguilar Range and the Glasshouse Mountains surrounds. Wamuran originally was known as "Wararba" from its inception as a timber town from the 1870s by the land selectors and timber cutters and loggers. Since then Wamuran has become well known for its farming industry. Maize grown in the district was delivered by bullock wagons driven from Mt Mee to Caboolture where it was sold for about 4d a bushel.

Dairy & beef cattle played a big part in Wamuran's early history. With the advent of the Caboolture Butter Factory and since the arrival of Wamuran's railway in 1909, diary farming became the staple source of income. Bananas were introduced in 1910 by Charlie Hall and have continued to grow into a solid industry. Pineapples were planted by Harry Westacott in 1919 and Wamuran became one of the largest pineapple producing areas in Qld

Local tobacco farmer Roy Ziviani had the highest tobacco prices in Queensland for some years during the popular tobacco years in the 1960's and 1970's. In 1929 Syd Childs planted passionfruit up on "Passionfruit Ridge" in the mountains and became the first commercial passionfruit farmer in Queensland. Strawberries have become a large industry for the district in recent years.

Wamuran consists of many and varied types of farming and breeding of horses, ostriches, deer and alpacas.

The District's Forged Highway Routes

The first road travelled by horse & sulkies and bullock wagons tracked from Brisbane and winding through Wamuran (then known as Waraba) onto Woodford. The highway went via Old Northern Road, crossing Caboolture River Road, journeying along Old North Road, over Zillman's crossing, along what is now W. Lindsay Road, crossing Campbell's Pocket Road into Flux Road, following the spur onto R. Williams & Pedwell Roads, then onto McLeod Lane to Woodford Road and arriving at Woodford. Many locals will know these roads which are well travelled today. Cobb & Co Coaches traveled onto Bushman's Arm Paddy Pinch Hotel, situated below the big climb at Bracalba. This hotel was relocated to the top of the range at D'Aguilar in 1910 where it still stands today.

National Servicemen's Memorial Park

On the 2nd August 2002 the Wamuran National Servicemen's Memorial Park was officially opened. Annual Anzac Day & Remembrance Day Services are given a personal touch and are well-attended by the community, with the local Wamuran State School Choir & Band and Tullawong High School Band & bugler, local school captains' involvement plus a lone piper and an aircraft fly-over by a retired Squadron Leader & his team, attending every year.

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT
Dr ALEX MARKWELL E: a.markwell@amaq.com.au P: (07) 3872 2222,

Update from AMAQ President

Recently AMA Queensland reviewed the State Government's 'Blueprint for better healthcare in Queensland' which outlines key priority areas for reform within the Queensland health system.
Our initial response is 'cautious optimism' about some of the initiatives and proposed reforms which, if implemented with efficiency and transparency, have the potential to improve health outcomes for many Queenslanders.

I have stated publicly that while this document holds some promise on the surface, AMA Queensland will reserve full judgement until we receive specific detail from the Government on how some of these initiatives will be achieved.

The move towards improved transparency and accountability is a step forward but the challenge will be to ensure that we are reporting on the right things so Queenslanders get a true reflection of our health system.

The mechanism to allow health employees to report unnecessary waste and make suggestions to improve the system bypassing the bureaucracy is also a positive sign.

Feedback from our members since the release of the 'Blueprint' has been varied with concerns centred on the privatisation of hospital services and the potential to alter Award agreements in favour of individual employment contracts.

This has done nothing to allay the insecurity of doctors working in the public system as they fear such changes will lead to fewer opportunities, particularly for clinical training, and the erosion of hard-fought working conditions.

As expressed by one concerned AMA Queensland member,

"A privatised public hospital would be highly unlikely to attract the quality researchers and educators required to train quality future health workers across a range of disciplines and to contribute to clinical research in the manner such institutions should be obliged to deliver."

Although AMA Queensland has expressed openness to the expansion of partnerships with the private and not for profit sectors, this should not be read as an endorsement of full privatisation but a willingness to explore new models of care.

We are in the process of developing a policy on privatisation of health care and encourage all AMA Queensland and LMA members to participate in the discussion by letting us know what you think.

I am keenly aware of how important these issues are for all members, especially our colleagues on the Sunshine Coast who have fought long and valiantly on behalf of their patients for expanded local hospital services.

Please be assured that AMA Queensland is sensitive to these needs and will work closely with members and the government to negotiate a satisfactory outcome. Again I emphasize the need for members to be involved in the discussion as there is no substitute for active clinician engagement.

I look forward to receiving your comments at membership@amaq.com.au.

Kind regards,

Dr Alex Markwell
AMA Queensland President

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

Medical Law and Administration

The Jayant Patel re-trial raises again a whole series of questions about medical law and administration. The AMA would decline to comment on any individual case alleging fault in a doctor – that is a matter for a jury that has been given all of the admissible evidence. But the AMA has to think long and hard about some of the issues raised.

Most simply, there is the question of standards of care. Doctors should not have to work in an environment of fear, constantly worried that they might be sued in a civil court – but we do. Now we also have to worry that an adverse outcome might lead to a criminal charge as well as the civil charge. We can take some comfort in knowing that the criminal standard of proof ("beyond reasonable doubt") is higher than the civil standard ("on the balance of probabilities"). But where will the law draw the line in the sand that separates a bad-luck outcome from criminal negligence or even culpable manslaughter?

The ultimate question for doctors to ponder is whether doctors could EVER be so negligent as to activate criminal proceedings. The case of an anaesthetist who wilfully infects patients with a blood-borne virus is not in the same league as a surgeon who presumably believed that he was doing the best he could for his patients – the difference lies in what the doctors' INTENT was. If there was no malicious intent, should an adverse medical outcome ever trigger the criminal law?

Next there comes the curious question of why the prosecutor should insist on pursuing the remaining charges against Patel when the first re-trial (presumably the one where the prosecutor had the best chance of securing a conviction) failed. There is immense political pressure from the survivors and relatives to achieve what they perceive as justice. But where do you draw the line between true justice and personal revenge? Is the prosecutor pursuing a witch hunt to satisfy private desires for revenge? Or is the prosecutor doing what he is supposed to do – the ancient Greeks changed the ancient laws based on private revenge in homicide cases to new laws based on revenge for society, not for individuals. I don't know how much the prosecutor's decision to proceed was based on a genuine desire for what all would objectively judge to be revenge, and how much the decision might have been based on a need for the public to see that even doctors cannot harm individuals with impunity. Again, where does the line in the sand get drawn between justice and personal motivations?

Thirdly, I have always been troubled that one individual doctor has been pursued while attention is drawn away from the system that created the environment in which patients did suffer adverse outcomes. Patel was originally appointed to a junior supervised position and was promoted to a senior unsupervised position for which he was not originally thought to be qualified.

Complaints were made, and most of those complaints stopped at the desk of a middle administrator, who has since left the system and escaped much public attention. Queensland Health has escaped virtually unscathed from public scrutiny about the system that placed a surgeon into a position where he probably should not have been, and that then perpetuated the error by failing to remedy perceived faults that arose from that appointment.

Yes, the Patel case, and the opening of old debates, gives us cause to ponder such questions. The revival of old debates is not a AMA policy – the reflections above are my own. But doctors of the future need to have some of the boundaries defined clearly for the world in which they are going to have to work long after I lay down my pen for the last time.

Wayne Herdy.

RDMA February Meeting 26.02.2013

Chaired by Vice President Kimberley Bondeson, Speaker Dr Grant Cracknell, Topic: When does 70 and 7 not fit, A Case Study Presentation, Sponsored jointly by Warner Chilcott & Sanofi,




Centre top clock wise; Dr Grant Cracknell - Speaker, Warner Chilcott Sponsors: Glen Renner & Tanya Olek (Mgr), Bob Edwards & Mal Mohanlal, Vice President Kimberley Bondeson & Grant Cracknell, Joint sponsors, **New member:** Arj Somasundarm & James Ling, Margaret MacPherson & Andrew Butler, Sanofi Sponsors: Jordanna Kerr & Rod Havers.




Is it not

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: **Wednesday 27th March 2013**

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: bioCSL
7.40pm	Speaker: Dr Jamie Reynolds Topic: Urology Matters: Lower Urinary tract symptoms- Treatment considerations.
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: tracey.blackmur@qml.com.au
t: 3049 4444 by Friday 22nd March

QML Pathology.

RDMA VICE PRESIDENT
Dr KIMBERLEY BONDESON

"Hot Topics"

I recently read an article in Australian Doctor, written by a GP, who worked in General Practice from 1986 to 2007.

He said he took little interest in medical politics, and found this was a mistake, because while he wasn't looking, his profession was hijacked by bureaucrats and lawyers.

He is referring to retired doctors no long having rights to write prescriptions or referrals. He pointed out however, that he can still teach or take on advisory roles. He is quite disgusted, and refuses to renew his medical registration, preferring to donate the money to charity. (See Australian Doctor, pg 21, 22nd March, 2013.)

I quite agree with him, as I am sure do many of my colleagues. When the rights of retired doctors were being debated, I was not involved with medical politics, and whilst aware that something was afoot, was not aware of actual details.

Whilst it is time consuming and at times frustrating, I am still attending meetings and committees with the AMAQ.

The latest Medico-Legal issue which is unfolding is surrounding the demise of the Queensland Medical Board, and its replacement by AHPRA (Australian Health Practitioner Regulation Agency) and the HQCC (Health Quality Complaints Commission).

The system currently in place for registration of doctors and other health practitioners as well as dealing with complaints is now more complicated, and involves duplication of services.

We all know that our Medical Registration fee has increased dramatically.

We also know that there has been a 28% increase in complaints against medical practitioners in the last 12 months.

Queensland has a disproportionate increase in complaints against medical practitioners, compared to the rest of Australia.

The reasons for this are varied, and the Doctor Patel case is seen as one of the major reasons.

The current Queensland State Government is trying to streamline the process, and as details unfold, I will keep you up to date.

Believe me, we don't want to find ourselves in a worse situation with more expensive registration fees.

We recently worked out that a part-time doctor, working 2 sessions a week for 12 months, was working for 4 of those months out of the 12 simply to pay for their Registration.

This included their medical registration, college membership, and medical indemnity.

It did not include any other membership fees, eg. AMA or RDMA.

Kimberley BONDESON, Vice President RDMA

SNAPSHOT FROM THE PAST The Medical Advertising Debate
REDAMA Newsletter from Series 2 No 9 March 1991, page 7

• The Medical Advertising Debate

'Peninsula can expect rash of promotion by clinics': Exelby

DOCTORS in Brisbane's northside suburbs can expect a rash of 24-hour, bulk billing clinics to be established in their area in the next five years, Dr Graham Exelby told the Advertising Debate in February.

Speaking at the February meeting of the LMA, the president of the Gold Coast Branch of the AMA said the problem now confronting his area would spread north in quick time.

"You should be prepared to have to cope with clinics that are owned by corporations who can advertise and promote with immunity.

"The alternative is to be prepared to be business like and think in corporation terms yourselves," Dr Exelby told doctors at the meeting.

A special guest speaker in the debate, Dr Exelby several times offered conflicting views to State AMA treasurer and spokesman, Dr Graham Row.

Dr Row said the AMA had a role to play in taking back control of the profession's advertising practices.

"We know that advertising adds greatly to your costs so it is obvious that some real research is necessary to determine what is deemed necessary and what is over the top," Dr Row said.

State AMA treasurer, Dr GRAHAM ROW, listens intently to the debate on medical advertising at the February meeting of the Redcliffe and Districts LMA.

He floated the idea of the AMA becoming a corporation in its own right and "franchising" its branches.

The advertising of the medical profession would then be done by the association on behalf of all doctors throughout the State.

"This would be a way of promoting AMA membership by pointing patients in the direction of members who would be identified through the corporate logo," he said.

President, Dr David Brand, showed the meeting examples of brochures distributed by a southside clinic, promoting even free condoms.

He said it was this type of promotion which offended ethical practitioners but it might become the fashion if advertising rules and restrictions were opened up.

Ross Thompson, as public relations consultant to the association, said doctors had to decide how far they were prepared to go in becoming competitive businessmen in a corporate-style environment.

He said there were times during economic hardship that people had to decide whether to spend a dollar on food or medical treatment.

Doctors might have to compete for that dollar by promoting and marketing .

The other decision dealt with the need to distinguish between a classified advertisement in the local newspaper, against brochures and bus stop seats.

The debate, lasting more than an hour, adopted a motion that the AMA should have a bigger role in advertising the profession and AMA members in particular.

The result will be conveyed to the State branch of the AMA.

Hospital systems 'with the best'

Dr GEOFF HOOL

ANAESTHETIC systems at Redcliffe Hospital compare favourably with other parts of the world, according to LMA member Dr Geoff Hool.

Dr Hool, an anaesthetist at the hospital, has recently returned from a conference, "Day Surgery in the 1990s" held in Singapore.

The conference was organised by the Singapore Society of Anaesthesiologists, and attracted delegates from Canada, the UK and the Far East.

"I was particularly interested to compare the Redcliffe Hospital system with outer parts of the world," he said.

"I was proud to note that the Redcliffe system compares very favourably with other international systems.

"Our organisation is excellent."

Dr Hool said said one of the main thrusts of the conference was that it was necessary to give clear instructions to patients so that they understood what was involved.

The most common cause of unplanned hospital, overnight admission, related to anaesthesia, was nausea and vomiting.

After returning to Australia, Dr Hool reviewed Redcliffe Hospital's first 100 cases.

"I discovered that we had no instance of overnight review, although there had been many laparoscopies done," he said.

Other points from the conference included information that surgical complications presented from a series of 10,000 at Singapore General Hospital had resulted in two percent of cases having to stay overnight.

This was most commonly due to pain, bleeding, or the operation being more extensive than first envisaged.

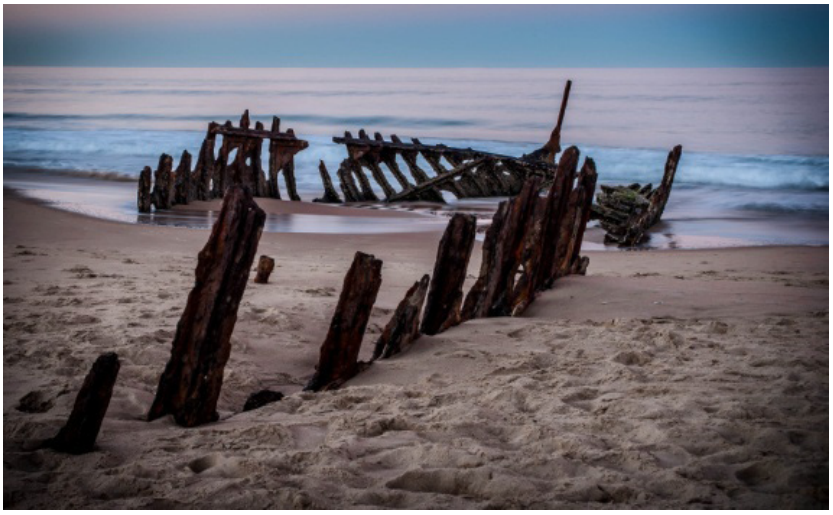
Dr Hool said Redcliffe Hospital surgeons were to be complimented on their patient selection for day surgery.

"We have not encountered the sort of problems they have in Singapore and the Redcliffe day surgery runs very smoothly," he said.

Australia a Visual Journey

Introducing local photographer Margie MacPherson (aka Margaret MacPherson). During 2012 Margie along with 14 other landscape photographers from around Australia collaborated to produce a truly beautiful coffee table book "Australia – A visual journey".

All the photographers have a passion for showing off this awesome country. From the far north, to the far south, and way out to the far west. This book would make a great addition to your library or a gift for that someone special.



We all hope you enjoy this visual journey of our beautiful country.

Price $49.95 plus P&H
P&H within Australia $15.00

For more of Margie's work please visit her website www.margiemimages.com or contact Margie directly via email: mm_29@bigpond.com or mob: 0477 554 125

Please Help:

Recently a heart breaking challenge has touched Margie's life. A 7 year old little girl within her extended family has recently been diagnosed with a childhood cancer. The only treatment available is located a 2 hour drive away. The family live too close to a major city to qualify for Care flight but are too far away to commute daily for treatment. The treatment is expected to last 12 months which means she and her Mum must remain in hospital for the duration.

Apart from having to deal with a very sick little girl the family's other 2 children and father must remain in their hometown which will not allow this remarkable family to be together for a long time.

This family is an example of many other families faced with similar challenges when a loved one becomes very ill.

It is for this reason that 10% of the profits from the sale of "Australia – a visual journey" will be donated to the Princess Margaret Hospital Perth who have been so wonderful during this awful time.

MEDICAL MOTORING with Doctor Clive Fraser

Motoring Article #100
Safe motoring,
doctorclivefraser@hotmail.com.

Victa Sabre "Motoring In The Backyard"

In 1983 most junior doctors (called residents) lived in at their hospitals in what was then known as the RMO Quarters. Usually consisting of a small room with shared facilities the rooms were definitely not opulent. But with hot meals in the dining room and a weekly cost of about $30 there were no complaints.

On an intern's salary with student loans to re-pay a room in the RMO Quarters seemed like a reasonable trade-off for all that un-paid over-time. Inevitably the cramped rooms and lack of privacy led most of us to eventually move out.

I purchased a small house in suburbia with a small backyard and some grass to mow. Obligingly the previous owner had left behind a push mower in the shed.

Whilst it could do the job I thought buying a proper lawn mower wouldn't be an extravagant purchase as there was no possibility that I'd ever move back into the RMO Quarters.

For $399 I bought myself a brand new 160cc 2 stroke Victa Sabre.

On Saturday mornings the whole neighbourhood would resonate to the sounds of Victas turning grass into lawn.

Apparently unstoppable I still own my trusty Victa 2 stroke. The wheels (like my legs) are getting wobbly, but the engine always starts and it has never let me down.

That was until I decided to use it as a mulcher on a small stump in the backyard. All of a sudden there was an almighty screeching sound coming from below the deck. I shut it down to check the damage and found I'd sheared off the base-plate.

After thirty years of regular use I could hardly start complaining and my Victa was never designed to be used as a stump grinder anyway.

I replaced the base-plate with a new one from the mower store, but for the first time ever my Victa wouldn't start.

I took the spark plug out and turned the engine over and there was that familiar smell of 2 stroke fuel. I plugged the spark plug into the lead and placed it against the motor and there was no spark, something akin to my mower going into asystole.

I reasoned that the impact with the stump had somehow damaged or displaced the coil and I started dismantling my Victa to investigate.

On old Victa 2 strokes the flywheel contains a magnet which rotates past a static coil producing 25,000 volts. That's the voltage needed to jump 0.025 inch across the spark plug's gap.

Everything seemed intact, but the impact with the stump may have knocked the coil away from the flywheel just a fraction. The magnet would be just too far away as it rotates past the coil and no spark would be the result.

It was at this point that I did what most of my patients do and I started scouring the internet for tips on how to diagnose and treat my ignition problem.

The best help came from Youtube where there are hundreds/ thousands of clips about small engine repairs.

You see the flywheel air gap should be 0.25mm or 0.010 inches and my gap seemed much bigger than that.

I saw on a Youtube clip that a business card taped to the flywheel was just about the right thickness.

I loosened the coil which then firmly stuck to the flywheel as the magnet is very powerful.

I tightened the coil up in that position, removed the business card and voila one pull and the mower started.

Will my Victa 2 stroke mower last another 30 years?

Probably!

2 Stroke Mowers

Advantages:
Higher revving than 4 stroke
More powerful
No need to change the sump oil
Motor will run at any angle
Mower can be tipped to change blades

Disadvantages:
Noisier than 4 stroke
Thirstier
Fuel has to be pre-mixed with oil

Safe motoring,
Doctor Clive Fraser

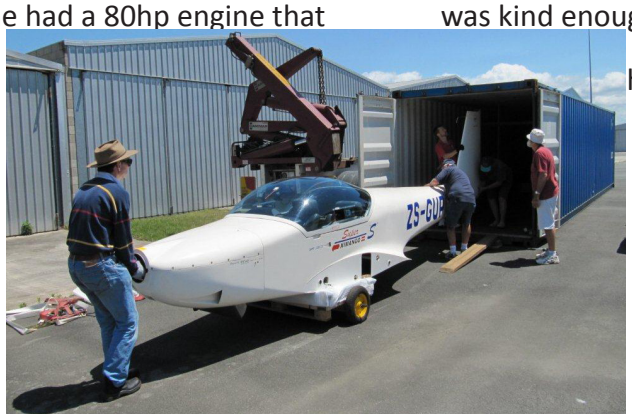
An Exercise in Patience
by Peter Stephenson

Instead of dreading my next decade birthday, I thought that I would make myself look forward to my sixtieth on my 58th birthday in October 2009. To this end, I decided that I would continue ticking off my bucket list by investing in a motor-glider as my 60th. Birthday present.

If you want to own an aircraft, you need somewhere to keep it. My nearby airfield is Redcliffe and there was nowhere to keep it there so I put the word about to my mates who had hangars there that I was in the market for one. I used to ride out to the airfield on my push-bike and make a nuisance of myself. Out of the blue, one came up and I was "in like Flynn" and purchased it.

Now for the motor-glider: I had seen one called a Ximango in Oshkosh USA (the biggest air show in the world) way back in 1996. It was a two seater and had side by side seating with the engine up front like a normal light aircraft. It also had folding wings that folded from 17 metres from tip to tip, down to 10 metres to make it fit into a normal hangar that is 15 metres wide.

I researched and wrote to the ten Ximango owners in Australia, telling them that I was in the market for one. Two replied and I went to see them and had a flight in each of them. One had a 80hp engine that was getting on in years yet he still wanted top dollar for it. The other was younger, 100hp and was even more expensive and he would not drop his price.



My wife who always likes a bargain and can pick one from 1500 feet above a shopping centre, went on research. She concluded that a new one from the factory in Brazil was only a bit more expensive than the local ones, and much better value for money. Who was I to argue when your wife wants to spend more money on *your* "toy"!

So in January 2011, after months of designing my instrument panel for the aircraft with Jim McCann, my USA agent, I finally placed a substantial deposit on a brand new 100hp Ximango via the American distributors who had two on order from the factory in Brazil. Serial number (S/N) 180 was my aircraft and six months was the delivery date. Next news I heard was an email from Chuck Cheeseman, Ximango USA proprietor informing me that Jim McCann had just died in motor glider (not a Ximango) accident as sole occupant, the cause of which has not been found. A really sad loss as he was such a great guy. A further few months passed and my 60th birthday was fast approaching with no sign of a delivery date.

Chuck then asks me whether I would accept S/N 178, a higher specification unit (bigger engine) but the same price (saving $10,000), as the Chinese purchasers were being slow in finalising their payment. Of course I said "yes" and was I getting excited?

However, by this time delivery from Brazil was not going to be in time for my 60th birthday so I was resigned to having to wait for it to arrive after it. Then Chuck told me that the Chinese had collected the S/N178 and the manufacturers had gone into administration. This meant that they could not refund me the deposit as their funds were frozen but I was placed on the list of creditors. Bummer!

Back to my trusty wife Gabrielle who gets back on the net and finds a 100hp Ximango in Stellenbosch, Cape Town South Africa with very low flying hours and made in 2001. She also found an older 80hp in Connecticut, USA. I was onto the owner of the 100hp like a flash. He was not answering his emails so I rang Stellenbosch Aero Club and got his phone number and rang him up. His price was just right and I had a good friend who lived 15 mins away who was kind enough to confirm the a/c was as good as advertised. However, he was having second thoughts on selling and took the a/c off the market. He was only selling because he had financial problems and had been given a lifeline of selling a share in his Ximango. Another disappointment!

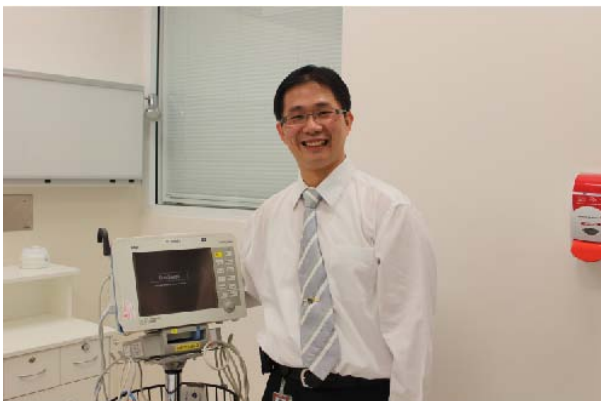
Back to the 80hp in the USA. Just as I was negotiating a price with the owner of the one in the USA, back comes the South African owner agreeing to the deal. Excellent! Down goes another substantial deposit, and I pay the balance on S/N 129 as soon as the a/c is in a container. Container is delivered to the docks with 30 minutes to spare to catch the ship that it was booked on. Damn; the ship has been overbooked so the next ship is leaving in 10 days time!

I was able to watch the ship via the net as it crept its way across the Indian Ocean to Singapore. It is transhipped to another and after a month at sea the container arrives in Brisbane a week after my 61st

(Continued page 13)

REDCLIFFE HOSPITAL EXECUTIVE DIRECTOR REPORT
Dr DONNA O'SULLIVAN

Cross - Tasman Move for Gastroenterologist



Gastroenterologist … Dr Antony Pan

Welcome to Gastroenterologist Dr Antony Pan, who started at Redcliffe Hospital as a resident consultant in January 2013. Dr Pan brings with him a wealth of experience in the prevention and cure of diseases and abnormalities of the oesophagus, stomach, intestines, liver and pancreas.

Dr Pan completed his medical training at the University of Auckland and has worked at various hospitals in New Zealand and recently at Middlemore Hospital, Waikato Hospital and Auckland Hospital.

"I'm thrilled to be here, this is the ideal place for me and my family and I look forward to serving my patients and the people of the peninsula", Dr Pan said.

Dr Pan will be performing a range of medical procedures including endoscopies and colonoscopies.

Having this specialist on site at the hospital is great for our patients and the peninsula community as it means the service is available locally.

We wish Dr Pan and his family well as they settle into life in Queensland.

Dr Donna O'Sullivan Executive Director and Director Medical Services

Continued from Page 12

birthday. I was warned that it could take 2 weeks to get it off the docks because of importation and fumigation. To my surprise it was ready in THREE days! I was not quite ready for that but a week after it arrived on the docks, I had it delivered to Redcliffe Airfield where my team of friends and an engineer was ready to de-containerise the aircraft in the allotted hour. Having the container any longer than one hour would start an expensive delivery clock. If the truck had to come back to collect the container, it was another $600.00 to pay.

I was very nervous opening the container. Was the packing done correctly? Had one of the crane drivers dropped it? Brilliant!: it was just as advertised and could not have been packed any better!. Putting it together was delayed by a label pointing to a connector showing that we had to twist it to drop the under carriage. We just could not get the wings together despite having all the connectors lined up spot on. Just before trying to put it together with the wheels up, I rang the owner of the Australian 100hp Ximango and he confirmed said that the undercarriage had to be up! So with a bit of pushing and pulling, it worked! Whew!

Reassembling the tail plane required a spare part that I got from the factory. They were very prompt in sending it and as I was a creditor, I got it for free. I also had all the engine piping tested and or replaced as they were still the original. In Australia, this is done every five years. The engineers were too busy to concentrate on my aircraft so it took two months before my first magic test flight just before Christmas 2012. What a double birthday/Christmas present, but what an exercise in patience!

Postscript: I am taking people up for air experience flights from Redcliffe Airfield: gift vouchers are available. Tel: 0407 160 253

PPS: my deposit in Brazil is closer to being refunded as the company is selling a property, and they could be back in production.

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Specialising in: prostate cancer, robotic surgery, BPH and renal cancers.

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956 Gympie Road, Chermside, 4032.

The question of whether PSA testing offers any benefit is topical. What should GPs advise their patients? Should it be tested at all? The following review is not exhaustive, but outlines the major studies dealing with PSA testing.

PSA GUIDELINES The Urological Society of Australia and New Zealand PSA testing guidelines state that a single initial PSA test and DRE should be offered to all men from age 40 after a discussion of the risks and benefits. In men aged 75-80 yrs, testing should be individualised. Men who have a PSA higher than the median for their age (PSA > 0.6 ng/mL, age 40-49 yrs) are at a higher risk for the development of prostate cancer (CaP) and should be followed more closely with annual PSA and DRE. Conversely, men with a PSA less than the median could be followed less frequently. Testing should then be performed annually from age 50. Men with a family history of CaP and African American men should undergo annual screening from age 40. Men with abnormal PSA values should be referred for urological assessment for possible biopsy, as should those who have a significant rise in PSA (PSA velocity) of >0.35/yr for PSA values <4.0, and >0.75 / yr for PSA values > 4, even if the total PSA is “normal”. Men with a low free:total PSA ratio should also be considered. A DRE should be performed as a “normal” PSA does not necessarily exclude CaP. A patient with an abnormal DRE even if the PSA is “normal” should be referred for urological assessment.

DOES PSA TESTING DECREASE PROSTATE CANCER MORTALITY? AIHW data demonstrates that CaP mortality decreased by 30% between 1993 and 2007 attributable to PSA testing.1 Similarly SEER database analysis of US data has shown a 44% reduction in CaP mortality between 1993 and 2009 again attributed to PSA testing.

The European Randomised Study of Screening for Prostate Cancer (ERSPC) reported on 182,160 men randomised to screening or no screening.2 There were 214 cancer deaths in the screening group and 326 deaths in the control group. After a median of 9 years follow-up, there was a 27% reduction in the risk of death from CaP. The number needed to treat (NNTT) to save one life in this trial was 48 while the number needed to screen (NNTS) was 1410. However the survival curves began to separate at 7 years suggesting that longer follow-up may show a more marked difference between the groups and consequently lower NNTT and NNTS.

Also the screening interval in this study was generally 4 years, indicating that men with more aggressive cancers may have missed an opportunity for cure.

This issue of longer follow-up was addressed by Schroder et al 2012 who reported an update of the ERSPC with 11 years of follow-up.3 Screening resulted in a 29% relative risk reduction in CaP mortality. The NNTS decreased to 1055 and the NNTT to 37. Similarly, after 14 years follow-up, the Göteborg prostate-cancer screening trial, in which 20,000 Swedish men were randomised to either screening or to no screening, demonstrated a 44% relative risk reduction.4 The NNTS was 293 and the NNTT was 12. By comparison the NNTS for breast cancer has been reported to be 1904 for women aged 39-49 years, 1339 for ages 50-59, and 377 for ages 60-69.5

The Tyrol Prostate Cancer Demonstration Project evaluated CaP mortality rates in the state of Tyrol in Austria, where PSA testing is widely available free of charge, in comparison to the rest of Austria where PSA testing was not freely available.6 Prostate cancer deaths in Tyrol in 2005 were 54% lower than expected compared to a 29% reduction in the rest of Austria which represented a 25% improvement.

Andriole et al (2009) published CaP mortality from the PLCO (Prostate, Lung, Colorectal and Ovarian) Cancer screening Trial in which 76 693 men were randomised to screening or usual care.7 The study concluded that there was no significant difference in CaP mortality between the 2 groups with 50 deaths in the screening group at 7 years and 44 in the control group. However this study has been criticised heavily because of significant contamination in the control group in which 52% of the controls had received

PSA testing by the 6th year. In addition 44.1% of patients in the control group had at least 1 PSA test at baseline and 53.9% of controls had a prior DRE. This trial is really one of more intense screening versus less intense screening, and not a trial of screening versus no screening. Also the median follow-up of only 6 years is far too short to show any meaningful difference. Updated 13 year data similarly did not show a benefit, however control group contamination remains a limitation.8 Crawford et al (2011) performed a sub-analysis of the PLCO study with 10 years follow-up correcting for concurrent significant co-morbidity.9 For those men with no significant co-morbidity, the number needed to treat to prevent one CaP death within 10 years was 5 suggesting that screening in healthy individuals may be of more benefit than indiscriminate PSA testing.

DOES TREATMENT IMPROVE SURVIVAL? In July 2012, the results of Prostate Intervention Versus Observation Trial (PIVOT) were published in the NEJM in which 731 men with localized CaP were randomly assigned to radical prostatectomy (RP) or observation.10 During the median follow-up of 10.0 years, 47.0% assigned to RP died, as compared with 49.9% assigned to observation. Among men assigned to RP, 5.8% died from CaP or treatment, as compared with 8.4% assigned to observation. RP was associated with reduced all-cause mortality among men with PSA values greater than 10ng/ml, and possibly among those with intermediate- or high- risk tumours. The authors concluded that RP did not significantly reduce all-cause or prostate-cancer mortality. However this trial has been severely criticised for being significantly underpowered.11 The trial was originally designed to analyse 2000 men with a follow-up of 15 years. However recruitment was problematic and only 731 men were enrolled. Indeed a minimum of 1200 patients would have been required to show a 25% mortality reduction. Additionally the follow up period was reduced from 15 years to 10 years.

In contrast Bill-Axelson (2011) reported the results of a randomised trial comparing radical prostatectomy to watchful waiting in early CaP in which 695 men with 'early' CaP from 14 Scandanavian centres who were randomly assigned to watchful waiting or RP from 1989 through 1999.12 During a median of 12.8 years, 166 of the 347 men in the RP group and 201 of the 348 in the watchful-waiting group died (P=0.007). The survival benefit was confined to men younger than 65 years of age. However, the study includes patients detected with CaP at a later stage than is usually diagnosed currently with only 12% of participants having had impalpable disease on prostate examination. The NNTT was 15 overall and 7 for men younger than 65 years of age. Additionally, significantly fewer distant metastases were diagnosed in the RP group.

Recently the US Preventative Services Task Force recommended against PSA screening.13 However the analysis undertaken as the basis for this recommendation was criticised heavily for emphasising the findings of the large but severely flawed PLCO trial while discounting the trials with longer follow-up such as the Goteborg study.

CONCLUSION In Australia in 2007, there were 2938 CaP deaths representing the second leading cause of cancer mortality in men, and was more than the 2680 breast cancer deaths in women.1 Thus CaP remains a significant men's health issue. Indiscriminate PSA testing irrespective of age and co-morbidities may not be of benefit. However, judicious PSA testing in men likely to benefit appears to be of value. Concern exists regarding detection and overtreatment of clinically insignificant disease. In this review I have not addressed the role active surveillance (AS) in CaP.

However AS is becoming increasingly utilised as an alternative management strategy and may mitigate potential overtreatment. Perhaps also, investigational diagnostic techniques such as multi-parametric MRI may in future allow more accurate diagnosis of CaP and avoid detection of insignificant disease. We should not ignore PSA testing. Rather we need to use PSA testing judiciously, while continuing to refine diagnostic and management strategies.

CONTACT Please feel free to call me directly on my mobile on 0437217011 at any time.

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Will Power.

AUTHOR:

Dr Mal Mohanlal

So you think you need will power to achieve something or perform a task or break a habit? There are so many desires operating within you and you want to override these with one strong desire because that is what you want at present.

Do you know that using will power is just an ego building or ego strengthening exercise? It is a false perception and a stressful habit which leads to anxiety, tension and conflict within the individual.

When you use will power do you know what you are doing?

When you are using will power you are fighting with yourself. One part of you says do this, and the other part says do that.

It is a conflict of desires.

So if you want to give up smoking and one part of you says you should give up smoking, and the other part says you want to continue smoking, what do you do?

Most people use will power to overcome a habit such as smoking. That is they use their stronger desire to stop smoking to override their weaker desire to continue smoking. When this happens, some will find that it makes them feel great because they have achieved something, others will no doubt find it a struggle. This can be permanent or temporary situation depending on the person's perception.

However this is achieved at a price. The person who is struggling can be in terrible conflict and feel miserable because there is no insight into what one is doing.

When one uses will power to suppress the weaker desire, there is tension created in the individual's subconscious mind because there was very little understanding of the weaker desire.

So one day, when the right moment arises, the weaker desire becomes strong again, one will find that one can easily go back to square one, that is, resuming smoking again.

Same thing happens when one is using will power to reduce weight. You might go on a diet etc to lose weight using your will power. And you may succeed in your efforts but since you have not understood your desires, you are likely to go back to square one, that is, gaining weight again.

Surely using will power is not the way to go. It is just an ego building exercise and a false pursuit. Your need to use will power arises when there are several conflicting desires opposing what you want.

However, if you had only one desire, do you need will power?

Read The Enchanted Time Traveller and learn how you can change your habits without using will power through your power of perception.

Self-knowledge is the beginning of meditation. Discover the power within you. Visit website: http://theenchantedtimetraveller.com.au/ The book is also available as an ebook.

Interesting Tidbits NATTY MOMENTS:

The Old Ones Are Still Good!

1. Two blondes walk into a building ..... you'd think at least one of them would have seen it.
2. Phone answering machine message - '...If you want to buy marijuana, press the hash key...
3. I went to buy some camouflage trousers the other day but I couldn't find any.
4. I went to the butchers the other day and I bet him 50 quid that he couldn't reach the meat off the top shelf. He said, 'No, the steaks are too high.'
5. My friend drowned in a bowl of muesli. A strong currant pulled him in.
6. I went to a seafood disco last week and pulled a muscle.
7. Two Eskimos sitting in a kayak were chilly. They lit a fire in the craft, it sank, proving once and for all that you can't have your kayak and heat it.
8. Our ice cream man was found lying on the floor of his van covered with hundreds and thousands. Police say that he topped himself.
9. Man goes to the doctor, with a strawberry growing out of his head. Doc says 'I'll give you some cream to put on it.'
10. 'Doc I can't stop singing 'The Green, Green Grass of Home'. 'That sounds like Tom Jones syndrome.' 'Is it common?' 'It's not unusual.'
11. A man takes his Rottweiler to the vet. 'My dog is cross-eyed, is there anything you can do for him?' 'Well,' said the vet, 'let's have a look at him'. So he picks the dog up and examines his eyes, then he checks his teeth. Finally, he says, 'I'm going to have to put him down.' 'What? Because he's cross-eyed?' 'No, because he's really heavy'.
12. What do you call a fish with no eyes? A fsh.
13. So I was getting into my car, and this bloke says to me 'Can you give me a lift?' I said 'Sure, you look great, the world's your oyster, go for it.'
14. Apparently, 1 in 5 people in the world are Chinese. There are 5 people in my family, so it must be one of them. It's either my mum or my Dad, or my older brother Colin, or my younger brother Ho-Cha-Chu. But I think it's Colin.
15. Police arrested two kids yesterday, one was drinking battery acid, and the other was eating fireworks. They charged one and let the other one off.
16. 'You know, somebody actually complimented me on my driving today. They left a little note on the windscreen. It said, 'Parking Fine.' So that was nice.'
17. A man walked into the doctors, he said, 'I've hurt my arm in several places'. The doctor said, 'Well don't go there anymore!

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NATIONAL PLAN AND ONGOING FUNDING NEEDED TO CONTINUE CLOSING THE GAP
National Close The Gap Day 2013

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

On National Close The Gap Day 2013, the AMA urges all Australian governments to build on the momentum that has seen some positive results in closing the gap and achieving health equality between Aboriginal people and Torres Strait Islanders and other Australians.

AMA President, Dr Steve Hambleton, said that closing the gap is a national priority that requires significant long-term funding and genuine political commitment from all governments.

"The AMA calls on the Federal and State and Territory Governments to renew their policy and funding commitments to the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes for another five years from 2013," Dr Hambleton said.

"This should be supported by an agreement by Australian governments, in partnership with Indigenous peoples, to develop a national strategic plan to close the gap."

The AMA recommends a national strategic plan that sets out action for:
• the health issues most responsible for child mortality and life expectancy gaps;

• the health services needed to address those issues (including a service gap analysis, workforce and infrastructure capacity building plan, and an appropriate service delivery model);

• a funding strategy based on a 'fair share' of public health resources and access to mainstream services for Indigenous Australians;

• a mechanism for coordinating national/ jurisdictional and regional plans and processes; and

• a binding commitment to a concrete and practical implementation plan.

The AMA acknowledges the achievements of the national efforts to close the gap, including:
• being on track to halve the mortality rates for children under five;

• significantly increasing Aboriginal and Torres Strait Islander peoples' access to health services for chronic disease - which underlies much of the gap in health outcomes;

• work underway in partnership with Aboriginal and Torres Strait Islander peoples to develop a long-term health plan; and

• meeting the target for early childhood education access in remote communities.

Dr Hambleton said that the momentum of goodwill and tangible action to close the gap must continue and grow so that we can build on these significant achievements.

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

Follow the AMA President and AMA Media on :
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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

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CHANGES TO CLASSIFIEDS

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

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Classifieds are not to be used as advertisements.

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The Redcliffe and District Medical Association Inc. have 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.

Subscriptions for January 2013 until the 30th June 2013 will be $50.00 or annual subscription is $100.00. **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. Suggestions on topics and/ or speakers are very welcome.

Please can you endeavour to pay your subscription by internet banking as it is so much easier for all concerned as it saves 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

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