RDMA
REDCLIFFE & DISTRICT
LOCAL MEDICAL ASSOCIATION

Newsletter
OCTOBER 2013

Bribie Island Bridge

See Bribie Island's Bridge in our historical article in our regular Where We Live And Work segments pages 5 & 20.

President's Message . Dr KIMBERLEY BONDESON

Presidents Report

An update on the Redcliffe Superclinic is that it was due to be opened with 3 General Practitioners by the end of September, before the general election. Obviously this has still not happened, and the date has been extended to the end of 2013.

The Redcliffe 5 story GP Superclinic is still a virtual shell, 6 years after it was pledged. This concept of the Superclinic was first put forth by Kevin Rudd in 2007.

The Redcliffe Superclinics first scheduled opening date was June 2011. It was given a $3.2 million rescue package after running out of funds. Early 2012 was the revised completion date given by the Dept of Health. In March 2013, the new owners, Queensland Health have given 2 dates, one september 2013 and now another before the end of the year.

This saga is ongoing, and we will just keep watching.

Now, in the Courier Mail and the Herald Sun, the GP superclinics are been blamed for lack of after hour services, putting the burdon on the hospital emergency departments.

This is interesting, as the Redcliffe Superclinic is not even open. The article states that the problem with the the GP Superclinics is that they are bringing new players into the local scene and this is making the existing players less viable.

This is making it tougher for existing Gps to help patients.

There are a further 6 GP Superclinics, including Mt Isa, Townsville, and Gladstone still have not opened, while 4 other clinics promised in 2010 do not even have a funding agreements.

The funding promised for these superclinics was in total $650 million.

What a waste!

Kimberley Bondeson
RDMA President

RDMA WELCOMES
A Message From

Dr BOB BROWN,
President Northside Local Medical Association

Significant Savings and Less Bureaucratic Intrusion in Hospitals and Private Practice.

Continued on Page 3

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

CPD Points & Attendance Certificate Available

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
AGM - Tuesday August 27th
Wednesday September 18th
Tuesday October 29th

End of Year Networking Function

Next Meeting

Friday November 29th

NOVEMBER NEWSLETTER 2013

The 19th November 2013 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com

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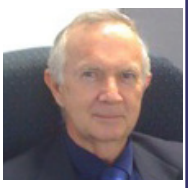

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NORTHSIDE LOCAL MEDICAL ASSOCIATION PRESIDENT
Dr ROBERT (BOB) BROWN

Significant Savings and Less Bureaucratic Intrusion in Hospitals and Private Practice.

It is with interest that I will be watching the behaviour of the Queensland Government and the Federal Government towards the frequently espoused belief in small government and excessive bureaucratic red tape as it applies to Health.

I am naively hoping that action will follow words and we may see significant savings and less bureaucratic intrusion in our hospitals and in private practice.

The problem is that governments and bureaucrats never seem to be able to deliver on theses promises, possibly because the bureaucracy and government are unwilling to admit to the patently obvious – that they are too costly, too repetitive and too unwieldy.

There is no doubt that our public hospitals; community health and public health need more money.

Similarly, we are all sick and tired of our Medicare entitlements being used and trivialised by politicians feeling free to reduce patient rebates (and not index them) to save money in the budgetary processes.

If the federal government continues to abuse the rights of our citizens to adequate medicate rebates when they see a private doctor, then what about reverting to private insurers being able to re-enter the market to help cover the inevitable and increasing costs of gap payments?

Medicare is no longer able to (and governments are obviously unwilling) to adequately fund first world medicine in Australia.

Our public hospitals do a wonderful job in supporting the public but only at the increasing use of rationing of services.

Hence the often ridiculously long waiting lists. In some cases, as an example, cataracts, are either not being performed or only when people can no longer see sufficiently well to hold a drivers licence.

This is not first world medicine, and it can only get worse unless fundamental changes are made to the system.

However, this must not be done without engaging the Australian people in a structured and transparent dialogue.

I would like to see that!

So, from a Queenslander's point of view, what are Mr Abbott and Mr Newman going to do about Health?

Are we to see positive and enlightened debate and action, or just more finger pointing?

Watch this space!

Dr Bob Brown,
President,
Northside Local Medical Association

October, 2013

2013 Bi-MEETING DATE CLAIMER:

For all Northside LMA Meeting & Membership queries contact:

Meeting Convener:

Miranda Russell, QML Marketing Office,
Contact Details;
Phone: (07) 3121 4574, Fax: (07) 3121 4972
Email: Miranda.Russell@qml.com.au

Meeting Treasurer:

Dr Graham McNally
Contact Details;
Phone: (07) 3265 3111
Postal Address: C/- Taigum Central Medical Practice, Shop 1, 217 Beams Rd, Taigum Qld 4018

Meeting Times: 7.00 pm for 7.30 pm

Next Meeting: 10th December 2013

2014 Dates:

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

Meeting President:

Dr Robert (Bob) Brown
Website and Link:
Northside Local Medical Association Website
Link: http://northsidelocalmedical.wordpress.com/

AUSTRALIAN MEDICAL ASSOCIATION QUEENSLAND PRESIDENT
Dr CHRISTIAN ROWAN

Queensland Health's Proposed Individual Contracts for Salaried and Visiting Medical Officers

Dear Members,

Over the past month AMA Queensland, and our partner union ASMOFQ, have been working closely to highlight our shared concerns over Queensland Health's proposed individual contracts for Salaried and Visiting Medical Officers.

It is the position of both AMA Queensland and ASMOFQ that the proposed contracts are unacceptable and require major changes before they are presented to the medical workforce.

We are also very concerned that the process is being 'rushed' and doesn't allow sufficient time or consultation to develop a contract that is fair and retains and protects current employment terms and working conditions; you may remember that the Medical Officers Certified Agreement (MOCA 3) took 10 months of weekly negotiations to arrive at a satisfactory outcome.

To date, Queensland Health has provided a frustrating lack of detail on the forthcoming changes, generating uncertainty among SMOs and VMOs. We are demanding that any new contracts provide adequate safeguards to ensure the terms and conditions of employment cannot be changed, varied or reduced at any time.

Our key concerns are:
1. The apparent haste at which Queensland Health wants to progress these new arrangements, particularly noting the significant alterations to the current agreement. MOCA 3 expires 30 June 2015, yet Queensland Health wants SMOs to be transitioned to these new contractual arrangements by June 2014, with sign up by April 2014 (only six months away).

2. No specific financial information has been provided regarding remuneration, superannuation or private practice. It is critical that all entitlements, allowances and remuneration are maintained, and no SMO or VMO is disadvantaged as a result of the transition across to these contracts.

3. There is a significant risk that the decentralisation of employment to the 17 different Hospital and Health Services (HHSs), lacking in any central oversight, could result in working conditions varying greatly across the state.

Any individual HHS can vary the contract at any time without discussion and may also elect to engage a private commercial provider to run and operate the HHS.

AMA Queensland and ASMOFQ will continue to lobby the Government over these important issues and will advise LMA members of new information as it becomes available.

In the meantime, please ensure your membership is active as we need the support of all SMOs and VMOs to send a clear message on behalf of the profession.

Yours sincerely,

Dr Christian Rowan

AMA Queensland President

www.moretonbay.qld.gov.au/redcliffe-museum/

Bridge turns 50 (19/10/1963)

Bribie Island is separated from the mainland by Pumicestone Channel. In 1901 a fish cannery was opened at the northern end of the island and within 10 years freight and passenger shipping ran regular services to Bribie Island.

Traditionally a popular destination for tourists, by 1912 a handful of businessmen's large investment to turn Bribie Island into a tourist destination was realised.

They had built a jetty at Bongaree and commissioned a steamship; the SS Koopa built in Scotland then steamed out to Australia arriving in December 2011 to bring people by their thousands across from Brisbane.

From those early beginnings there were more people camped on Bribie Island in the 1920s then lived in the Caboolture Shire as a whole. The 'SS Koopa' (Aboriginal for Flying Fish) served Bribie Island from 1911 to 1953.

She was a steamer which came from Redcliffe originally SS Koopa ran from Brisbane to Woody Point, Redcliffe and Bribie Island. A barge also served the island and crossed the channel from Sandstone Point.

As late as the 1950s Bongaree Bribie's main settlement was still a sandy esplanade dotted with holiday houses, a general store and a local hall as the social centre.

By 1963 the population of Bribie was only about 600 people. A Bridge to give easier access to vehicles was the only way to further develop the Island's holiday appeal.

The other impetuses for the bridge was the Australian and American troops' huge army beach landing training camp dispatchments to the islands to prepare and fight the Japanese during the war.

After the war the army barges were taken over by civilians and used to bring cars across to the island starting the ferry service in 1947 continuing until the bridge was built. .

An election promise to build Bribie Island a Bridge by a local politician who became the then premier of the state was kept becoming a reality on 19/10/1963.

The Bribie Island Bridge gives captivating views of Pumicestone Passage and remains unchanged since it opening in 1963.

October this year marks the bridge's 50th year. Construction took 2 years without incident and at the time of construction it was the longest, pre-stressed, pre-cast concrete bridge in Australia and remains so today.

Spanning 2,736 feet (831.4 m), costing $716,321 with a 10 shilling toll, the bridge officially opened on Saturday October 19, 1963 by premier of Queensland Frank Nicklin.

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

AMA COUNCILLOR'S COLUMN

I have been a general practitioner for over 30 years. I have gone through a few complaints processes, one of which got to an out-of-Court settlement (which I thought grossly unfair because the complaint was undeserved, but the MDO decided it was cheaper to pay up than to defend). I have survived ungrateful patients and the frustration of treating patients to whom I had nothing to offer. I have been to disaster areas and practised in third-world conditions. There are times when I have passed through some pretty tough experiences.

Sometimes I feel that what I do is routine and humdrum. But sometimes I have to teach my trade to students and it suddenly comes home to me that what I do is not easy. Just watch the most talented student at their first attempt at suturing or syringeing ears.

Like most of my colleagues, I come home from work each day tired, but not aware of any stress from performing what has been a series of very complex decision-making processes. It is just what we do.

Now a new report from Beyond Blue has drawn what doctors FEEL sharply into focus. We have had another reality check that what we do every day is not simple, it can have shattering impacts on our patients' lives, and it is very, very stressful. We have just become numbed to the stress, but not immune.

The report declared that 20 per cent of medical students and 10 per cent of doctors had had suicidal thoughts in the preceding 12 months – rates much higher than the broader community - and a quarter of all doctors were likely to have a minor psychiatric disorder, such as mild depression or anxiety. We have high rates of drug dependence, alcoholism, broken marriages – you name it.

But we suffer from equally high rates of denial. We are very reluctant to seek help because of stigma surrounding mental health problems. And maybe we are too numbed by our continuous exposure to what are really extraordinary work conditions.

AMA President Dr Steve Hambleton told the Health Professionals' Health Conference in Brisbane earlier this month that "The AMA has now made the health and welfare of doctors a priority. As health professionals, we have a responsibility to ensure that programs exist to assist our colleagues to access quality health care when they need it."

Young doctors and female doctors are much more likely to suffer from the emotional traumas endemic in our profession. They have stressors that older doctors have already survived – making families and developing careers while trying to solve the financial burdens of many years without regular incomes.

Doctors in Training have for some years been drawing attention to predisposing factors, such as excessive work hours and acceptance of pathological work/life balance. Again, they are leading the profession in prompting the AMA to remind doctors to look after themselves – and to watch their colleagues for signs of trouble.

The new call is to de-stigmatize mental health disorders, especially stress-related illness in health professionals. As long as there is a stigma, doctors will be reluctant to ask for help – until it is too late.

Mandatory reporting has had the undesired effect of deterring doctors from seeking help. Doctors now decide not to seek access to the old state-based programmes that previously gave them at least some professional support.

No, doctors are not immune from stress. We do get depressed. We do get grossly dysfunctional. And we just keep doing our jobs, until something just breaks.

That has been the accepted old way of doctors' lives. That way of life now has to be relegated to history, just like the old cottage industry family practices.

We need to ensure that we do look after ourselves, emotionally as well as physically, and be there when our colleagues need us to look after them.

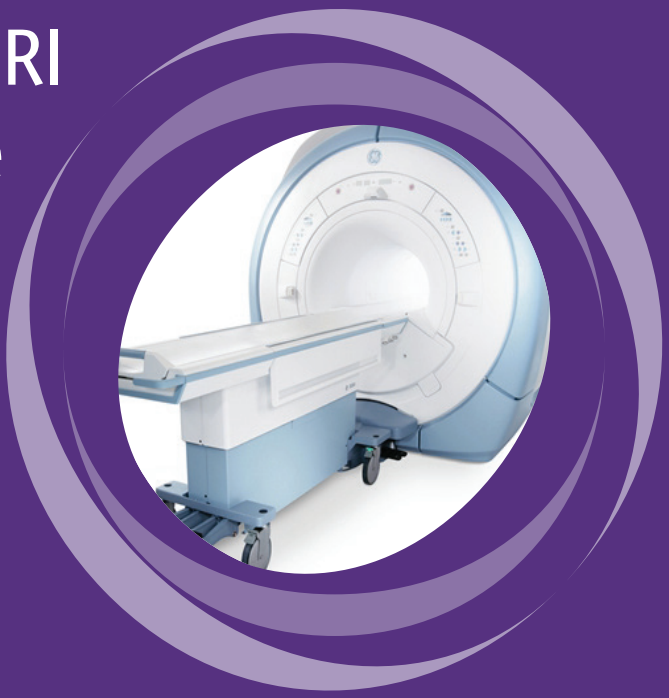
Wayne HERDY,
North Coast Branch Councillor, AMA Queensland.

Medicare eligible MRI scans now available at Qscan Redcliffe

Qscan Radiology Clinics are proud to announce that our Redcliffe MRI scanner now has a full Medicare license.

All Medicare eligible Specialist referred MRI scans will now be bulk billed.

All General Practitioner referred paediatric MRI scans that fit Medicare criteria are also bulk billed.



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REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: **Tuesday 29th October 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 Kimberley Bondeson - President RDMA Inc.
7.35pm	Sponsor: Moreton Eye Group
7.40pm	Speaker: Dr Graham Hay-Smith Topic: Not an island: Inflamed eyes and your whole patient
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 25th October 2013

QML Pathology.

AMAQ BRANCH COUNCILLOR REPORT GREATER BRISBANE AREA

Dr KIMBERLEY BONDESON

AMA COUNCILLOR'S COLUMN

Hello everyone, I have just returned from South America, where Dr Wayne Herdy and I attended the recent AMAQ conference in Santiago. The conference format was excellent, with Wayne's presentation on his experience in Banda Aceh's Tsunami in 2004 being very successful and inspiring. Well done Wayne, it was well received.

Santiago as a City itself is like the poor cousin of Madrid – a beautiful Spanish city that has not had the wealth or the preservation of it parent Spanish Country. The drive from the airport to the hotel was through slum townships. The city itself does not have many trees, and this is a problem for the people who live there, who in the small areas where they are able to grow trees, having only a small amount of greenery. The Santiago people themselves know that this is a problem, and are working towards planting more trees.

The highlight of this conference was, unexpectedly, the brief conference tour, were a group of 6 of us travelled from Santiago on an Andes Ancient Civilizations Tour. We visited briefly the ancient city of Cusco, visiting Mashu Picchu which was at 4,100 meters. This was an amazing ruin, where it appears that the ancient original indigenous people escaped to and preserved during the Spanish occupation. The walk up the stairs at altitude was quite difficult. The prior AMAQ group who had walked the trek pre-conference witnessed someone being evacuated in a body bag. Potentially very scary.

We then travelled to Puno, and visited the famous Titicaca Lake – amazing. These people's life span is 85 yo – and I can understand this, as they live a very simple life on their reed islands. The Spanish conquestors were never certain of the reed island population, as they kept moving their islands as the Spanish infiltrated the area. These simple people still continue to live a stress free life on their reed islands but their population is diminishing as the younger generation are charmed by city life. It was remarkable to see that many of the school children had to row a boat to the mainland to attend their school.

We then travelled from Puno to La Paz. And visited the Garden Stairs and Fountain of the Inca on the legendary Sun Island. By this time we were at 4,100 meters above sea level. Oxygen was available on the bus and on the boat for 5 to 10 minute bursts.

We then had to walk across the border to Bolivia – after arriving by truck. Our bags were carried across the border on bicycles. La Paz was an interesting city. Before the major part of the city, which is built effectively in what appears as a big volcanic crater, with 1 km difference in height between one part of the city and another, with a population of 1.5 million people. This pre-city area was an area of black markets. The local markets did not need any money to trade – it was a barter weekly market, with one hand of Llama wool in exchange for 1 hand of bananas. No money needed. The main street was extremely interesting, varying from gravel roads to proper sealed gravel roadways. As we drove past the main industry of the black market city appeared to be automobile repairs and parts, with many of the neighbouring towns and countries having to travel with their trucks and cars for repairs and maintenance.

The health system in Bolivia is also interesting. They have a free public health system, for pregnant mothers, up until 6 months after they deliver. The children have free public health up until the age of 5yo. Then the next group who are able to access free public health are the 60yo and above. The average life span is 65yo.

To fill in the gap between 5yo and 60yo, they rely on witch doctors. At the witch doctors market, we saw some incredible sights. It is common that the Sharman's (witchdoctors) use herbal medicine, which can commonly include llama foetuses, poison snakes preserving liquid, octopus, and various other ingredients. One of our guides told us they did not need Doctors in Bolivia, as they had such good Sharman's.

An incredibly interesting trip. Next month I will endeavour to show some of the photos.

A NEW WAY OF STEALING

http://www.immihelp.com/newcomer/credit-card-safety-tips.html

SCENE 1 .A friend went to the local gym placing his belongings in the locker. After the workout and a shower, he came out, saw the locker open, and thought, 'Funny, I thought I locked the locker... Hmm, 'He dressed and just flipped the wallet to make sure all was in order. Everything looked okay - all cards were in place...

A few weeks later his credit card bill came - a whooping bill of $14,000! He called the credit card company and started yelling at them, saying that he did not make the transactions. Customer care personnel verified that there was no mistake in the system and asked if his card had been stolen...'No,' he said, but then took out his wallet, pulled out the credit card, and yep - a switch had been made.

http://www.google.com.au/imgres?imgurl =http://fnbc.info/sites/default/files/fck-uploads/image/Financial_Literacy

An expired similar credit card from the same bank was in the wallet. The thief broke into his gym locker and switched cards. Verdict: The credit card issuer said since he did not report the card missing earlier, he'd have to pay the amount owed to them. How much did he have to pay for items he did not buy? $9,000! Why were there no calls made to verify the amount swiped? Small amounts rarely trigger a 'warning bell'!

SCENE 2 .A man at a local restaurant paid for his meal with his credit card. The bill for the meal came, he signed it and the waitress folded the receipt and passed the credit card along. Usually, he would just take it and place it in his wallet or pocket. Funny enough, though, he actually took a look at the card and, lo and behold, it was the expired card of another person.

He called the waitress and she looked perplexed. She took it back, apologised hurring back to the counter under the watchful eye of the man. All the waitress did while walking to the counter was wave the wrong expired card to the counter cashier. The counter cashier immediately looked down and took out the real card. No exchange of words --- nothing! She took it and came back to the man with an apology. (This scenario actually happened in our local hotel- -between the waitress and the front desk cashier.

Verdict: Make sure the credit cards in your wallet are yours. Check the name on the card every time you sign for something and/or the card is taken away for even a short period of time. better still accompany it. Many people just take back the credit card without even looking at it.

DO NOT LET YOU CREDIT CARD OUT OF YOUR SIGHT, CHECK IT EACH TIME IT IS RETURNED TO YOU AFTER A TRANSACTION!

SCENE 3: Last month I went into a Chinese restaurant to pick up an order that I had phoned. I paid with my Visa Check Card which, of course, is linked directly to my current Account. The young man behind the counter took my card, swiped it, laid it on the counter to wait to clear, a standard procedure. While he waited, he picked up his cell phone and dialed. I just noticed the phone because it is the same model my daughter uses, and nothing seemed out of the ordinary. Then I heard the click sound like her phone does taking a picture. He then gave me back my card but kept the phone in his hand as if he was still pressing buttons. I'm thinking: I wonder what he is taking a picture of, oblivious to what he was really doing.

It then dawned on me: the only thing there was my credit card, so now I started paying much closer attention... He set his phone on the counter, leaving it open. About five seconds later, I heard the chime indicated the picture has been saved.

I'm standing there struggling with the fact that this boy just took a picture of my credit card. I didn't say anything to him as the consequences had still not dawned on me. Yes, he had done it so smoothly, because if my daughter had not had the same kind of phone, I probably would never have realised what happened. Needless to say, I immediately walked to the bank and cancelled that card. Be aware of your surroundings at all times. When using your credit card take cautions and don't be careless. Notice who is standing near you and what they are doing when you use your card. Mobile phones have camera applications. Never let your card out of your sight.....check and check again!

REWARD FOR FLEET OF FEET

Dr Tim Finucan represented the consultants to receive the Pfizer Shield for the winners of this year's Medical Challenge in the Jetty to Jetty Fund Run in August. Pfizer State Manager, Warren Doherty, presented the trophy for the second year at the monthly dinner meeting of the Redcliffe and Districts Local Medical Association..
The consultants team of Dr Finucan, Steve Falconer, Peter Stride and Ross Boulton won the trophy ahead of teams from Pharmacy, Physios and GPs .
Picture shows Mr Doherty handing over the the shield in front of the rather appropriate Feldene poster.

Teleconference brought the medical profession together

SEVERAL positive aspects came out of the AMA's historic teleconference by SKY Channel according to Redcliffe and Districts LMA president, Dr Bob Brown.

Despite the short notice to encourage members to attend a SKY venue, Dr Brown believes the response indicates a growing awareness of the threats facing the medical profession.

The LMA organised a venue at Redcliffe Leagues Club for members while other groups gathered at Morayfield, Strathpine and Caboolture to watch the one-hour presentation.

Federal president, Dr Bruce Shepherd, headed the long list of specialist speakers who covered a wide range of topics of interest to general practice.

Dr Brown said that although attendance at the venues might be considered small, the follow through had been a groundswell of indignation, aggravation and action.

"I believe we will find more and more doctors turning to the AMA now that they can see how well it is preparing to fight off the threat of nationalisation and reduced health care standards in this country," he said.

He said an ominous sign for doctors came only two days after the teleconference when a Melbourne newspaper printed a report suggesting the Federal Government was considering a plan to charge people making a claim on Medicare.

There were obviously more subtle moves by the government to weaken the strength of the medical profession but the Melbourne report had frightening implications, he said.

"We are also concerned at the increased activity by Health Insurance Commission investigators and the apparent harassment of doctors.

"The AMA has published a handbook on guidelines on how to be interviewed by the HIC but many members are not aware of their rights in this matter.

"The first thing that should be pointed out is that the HIC must have an appointment to see a doctor and this requirement should be enforced at all times."

Dr Brown said the Redcliffe executive was investigating the purchase of a portable tape recorder which could be made available for use by doctors being interviewed by an HIC investigator.

However, the major positive point arising from the teleconference had been the almost universal decision by doctors to cease bulk billing, in accordance with the AMA recommendation.

The response to the Federal Budget and the reduction of $3.50 in Medicare rebates from November 1, had been to galvanise the profession, Dr Brown said.

There had been a noticeable increase in the number of doctors seeking information from the AMA or local associations and a strong acceptance of the recommendation that bulk billing be abandoned.

Putting our views to public

Public relations consultants, the Word Factory, have been asked to report on an advertising campaign aimed at giving the Redcliffe and Districts Local Medical Association views on Medicare and associated political matters.

The report will cover the cost of placing advertisements in selected local newspapers to coincide with the planned reduction in the Medicare rebate from November 1.

The advertisements would spell out the reasons for the elimination of bulk billing and the effect the government's actions will have on the delivery of health care in Australia.

President, Dr Bob Brown, said the Redcliffe LMA executive was looking at ways of establishing a "fighting fund" to finance the advertising programme.

He said the report was expected to be ready before the next meeting of the association on October 25.

Members who are interested in holding fund raising functions such as cocktail parties, barbecues or raffles are asked to contact any member of the executive.

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #107
Safe motoring,
doctorclivefraser@hotmail.com.

Mazda 6 Touring Diesel.
"Wisdom, Intelligence & Harmony"

Mazda has been making motor vehicles in Japan since 1931. Its predecessor, the Toyo Kogyo Company had made machine tools from 1920 until 1931 when its first vehicle, the Mazdago, ran off the production line. It was a three-wheeled "autorickshaw" with handle-bars and a one cylinder air-cooled engine.

During the Second World War Toyo Kogyo made armaments, most notably the Type 99 Arisaka infantry rifle. By the 1960's Mazda was investing heavily in the development of Wankel rotary engines and is now the sole world manufacturer.

The first Mazda sedan that took my eye was the Bertone-styled Mazda 1500 in 1966.

My father had considered buying the 1500, but bought a locally-made HR Holden instead. It had only been a generation since the Second World War. Japanese cars were yet to be trusted and there were un-founded doubts about reliability.

A friend bought a Mazda Capella in the 1970's and in 1980 I almost bought a Mazda 626, but opted for a Chrysler Sigma with a larger engine and lower longevity. Many 626's followed in the 1980's and in 1983 the Mazda 626 was the Wheels Magazine Car Of The Year.

Ford even manufactured a variant of the 626 in Australia, the Telstar. My partner owned a Telstar TX5 Ghia with an electronic dashboard, but it still wasn't exactly a Mazda. In 2003 Mazda changed their numbering system and released the Mazda 6 which is the subject of this month's road test.

Having never actually owned a Mazda myself, I desperately wanted to like this car as I had pencilled it onto my shopping list. I liked the way it looked, from the front. I liked the quality of the finish and the goodies inside.

Everything was going great until I turned the key (sorry keyless start) if you know what I mean.
I just didn't like the way it sounded. Having been spoilt by the quietness of Mercedes, BMW and VW diesels in ascending order I was a little surprised by how noisy the motor was, or at least how noisy it seemed compared to the formidably quieter competition.

There is no shortage of go from the diesel Mazda 6 with 129kW of power and 420Nm of torque. It takes off well from a standing start and like all diesels it doesn't lose momentum on hill climbs. Back in the traffic the i-Stop feature shuts the engine down when stopped. Whilst i-Stop saves fuel it is a little disconcerting at first.

With no motor running it's more like being parked at the traffic lights, but as soon as you take your foot off the brake pedal the motor always fires up and away you go. Going diesel in a Mazda 6 comes at a $3,000 price premium over the SkyActiv petrol. Power only drops by 7% by going from petrol-powered to diesel-powered, but torque is up by a whopping 68% making the diesel feel like it has two more cylinders. Fuel consumption overall is 18% better in the oil-burner.

Even the Mazda 6 base model is comprehensively equipped with keyless starting, dual-zone climate control, paddle shifter gear change, emergency brake assist, rain-sensing wipers and satellite navigation.

Going up-market to the top shelf Atenza adds leather seats, 19 inch wheels, radar cruise control, blind spot monitoring, lane departure warning, a sun-roof and Bi-Xenon headlights that turn around corners. A wagon is $1,300 more than a sedan. Overall I can see why the Mazda 6 is a favourite amongst the conservative bowls club members. It's a quality product at an affordable price.

If my hearing keeps on deteriorating I soon won't notice the clatter from the motor and some diesel aficionados even like that sound. Would I buy a Mazda6? Well, maybe. It's still on my list.

Mazda6 Diesel Atenza Wagon	
For:	Build quality, reliability and retained value.
Against:	Sounds like a diesel.
Car would suit:	Volvo drivers and older doctors like myself.
Specifications:	2.2 litre 16 valve 4 cylinder diesel
	129 kW power @ 4,500 rpm
	420 Nm torque @ 2,000 rpm
	6 speed automatic transmission
	5.4 l/100 km (combined)
	$55,000 on the road Qld, Vic and NT
	$55,500 on the road where IQ's are higher
Fast facts:	Only 4% of passenger vehicles sold in Australia are diesel-powered.
	The Mazda6 diesel is not currently sold in the USA.
	The name "Mazda" is taken from the Zoroastrian God of wisdom, intelligence and harmony.

Safe motoring, Doctor Clive Fraser

COMPUTERS & GADGETS

Email: apndx@hotmail.com.

with Doctor Daniel Mehanna

"The End of a Beautiful Relationship"

It finally happened. The relationship is over. It's really over. We have been together for almost 2 years. Through the good and the bad times. Although I have looked around at others, I have never once strayed to more attractive alternatives. Although I must admit, the temptation has been there. I have been utterly and completely faithful.

But yesterday my phone died. Well, not quite. In reality I killed it. I'm guilty, I admit it. Making my way down the stairs I clumsily dropped my Samsung Galaxy Nexus phone and heard an awful sound. The sound of the screen cracking. I hurriedly picked it up from the hard concrete floor but I was presented with several large cracks on the delicate screen. I was heart broken.

With (unfounded) optimism I pressed the on button to restart my friend but alas was greeted with nothing but a blank screen. The phone did however powerup (I felt the tell-tale vibration) but I quickly discovered however that my phone was useless. Although the electronics worked (apart from the screen), as it was a touch screen, not only could I not make calls but I could not even answer calls. And so the afternoon progressed with my phone ringing but unable to be answered.

So upon getting home, I dug around my electronics box and found my old trusty Nokia 6120 from 2007. Having not used it for years I admit was somewhat sceptical as to whether it would actually work. I mean, you're lucky if a modern smart phone lasts more than about 2 years, (they usually have a habit of self destruction just days after the warranty period expires). So to my surprise it actually booted. After inserting my SIM card, I made a test call and to my second surprise, it worked!! A marvel of the longevity of old technology.

This got me thinking just how much technology has progressed in 6 years and how much we take our technology for granted.

The Nokia has a 2 inch screen with a resolution of 320 X 240 pixels, Bluetooth, no touch screen, no Wi-Fi, no proper app store with a 2 meg rear camera and a processor running at 369 Mhz. But interestingly it is possible to browse the web using a rudimentary browser.

My Galaxy Nexus has a 4.65 inch touch screen with a resolution of 1280 X 720 pixels, Wi-Fi, gyroscope, accelerometer, barometer, proximity sensor with a 5 meg rear camera and a dual core processor running at 1.2 GHz and a separate processor for graphics. Quite a difference!!

But although the technology has progressed, it has not come without a cost. Compared to the old phones, our new Smartphones are power hungry (needing to the charged daily), delicate (breaking at the easiest drop) and sometimes not good at what a phone should do – make phone calls with high quality and clear sound.

It is also interesting how the size of phones have changed. When mobile phones first made their appearance they were very large, bulky and cumbersome. Over time the phones reduced in size and it was seen as a status symbol to have the smallest phone (I remember having coffee years ago in a trendy cafe in Sydney and all the yuppies would put their phones on the table in an effort to show their toys off to the world). Funnily enough, things are now going the other way, with phone sizes increasing to accommodate the increasing screen sizes of 5 inches or more. "The irony of it all"

But in every cloud there is a silver lining. My phone has died just weeks before the release of the long awaited Google Nexus 5...The phone the geeks of the world (including myself) have been salivating over for months. If only I can last the distance....I only have to use the old Nokia for a little bit longer!

But, in the meantime, if anyone is in the market for a great android phone, I suggest you go to the Google play store and grab a (soon to superseded) Nexus 4. Google are practically giving them away for about $300 including delivery. A real bargain! I actually ordered one before changing my mind and cancelling the order several minutes later – I just couldn't bring myself to do it, despite the incredible value for money. You see, I suffer from the curse of the technology addict – wanting the latest and greatest. It's what keeps the technology companies going!

Next month I hope to give you a review of my new Galaxy 5. Happy computing.

Going out on a limb here…

by Dr Ray Collins

When referring to the hand, the names Digitus pollicis, indicis, medius, annularis, and minimus specify the five ***fingers***. In situations of clinical relevance the use of such names can preclude anatomical ambiguity.

These time-tested terms have honoured the fingers, but the ***toes*** have been labelled only by number, except of course the great toe, or *Hallux*, as in Hallux valgus, or bunion.

Is it not time for the medical community in general, led of course by the iconoclasts of Redcliffe and District Medical Association, to have the ***toes*** no longer stand up and merely be counted?

I therefore submit for consideration the following nomenclature to refer to the pedal "digits".

For the Hallux: *Porcellus fori*; for the second toe: *P. domi*; for the third toe: *P. carnivorus*; for the fourth toe: *P. non voratus*; and for the fifth toe: *P. plorans domum*.

Using *Porcellus* as the diminutive form of *Porcus*, or pig, one can translate the suggested terminology as follows: piglet at market, piglet at home, meat-eating piglet, piglet having not eaten, and piglet crying homeward, respectively.

SNAPSHOT FROM THE PAST Hospital Closure Unsatisfactory
REDAMA Newsletter from Series 2 No 16 October 1991, Page 5

Brendan Nelson to bring us up to date

Members of Redcliffe and Districts Local Medical Association will be able to meet Federal AMA vice president, Dr Brendan Nelson, on October 26.

Dr Nelson, one of the most outstanding personalities to emerge in the AMA in recent years, has accepted an invitation to attend a lunch time meeting with the LMA.

He will be in Queensland for a series of meetings and updates on the Federal Budget debate.

President, Dr Bob Brown, said Dr Nelson had agreed to the Saturday lunch time meeting in between other meetings, to give members a chance to meet him personally in an informal atmosphere.

The barbeque luncheon will be held in the private Rocks Restaurant at Highway 26 Motor Inn, 9 Elizabeth Avenue, Clontarf from 12 noon to 2pm.

The function will be for members and their spouses and the charge will be $15 per head for the barbecue lunch.

Dr Brown said members would be able to discuss the $3.50 Medicare rebate issue or any other current AMA concerns with Dr Nelson who will be accompanied by his wife.

"By the time of the visit, we should know the recommendations of the Caucus sub-committee on the rebate issue so it will be an appropriate time to meet Dr Nelson," Dr Brown said.

Members intending to attend the lunch are asked to advise the secretary, Dr Alan Mahoney (284 1892) or treasurer, Dr Judy Tucker (265 4555).

Dr Nelson is a Tasmanian GP who has had an instant impact on the AMA since he became active two years ago.

He has become the association's media spokesman on several issues, mainly political.

The Redcliffe luncheon will be his only informal meeting on his Queensland tour.

The $3.50 Fiasco

Hospital closure is "not satisfactory"

THE Redcliffe and Districts Local Medical Association is not satisfied with explanations about the closure of certain facilities at Redcliffe Hospital over Christmas.

The association revealed in a media release on September 20 that facilities for elective surgery would be closed from December 13 to January 6.

The release, quoting association secretary, Dr Alan Mahoney, said the hospital had been forced to make cost cuts under the new regional health system.

Dr Mahoney, said doctors were gravely concerned to learn that one ward would be closed for the same time while staff take rostered, annual leave.

"The hospital closed these areas for ten days last Christmas but now the administration is being forced to extend the closure to three weeks as one way of achieving their very tight budget levels," Dr Mahoney said.

"The people who will be hardest hit will be those who chose to have surgery for long standing problems at a time when they have relatives available to look after their family.

"Many can only afford to go into hospital at this time of the year but now they will just have to have their operation later in the year and be forced to make other arrangements about baby-sitting," he said.

Dr Mahoney said that under the new Regional Health Authority system in Queensland, each hospital was given an annual budget.

"The allocation is insufficient so cuts have to be made somewhere but we cannot approve of a block shutdown over Christmas," he said.

The LMA has been told the hospital nursing staff have been rostered to take their leave over the three weeks.

Dr Mahoney said he understood that trauma or emergency accident cases would be treated but all elective surgery would be put back a minimum of three weeks, and probably more.

Although the criticism was levelled at the State Government, the association's stance was taken as a hit at hospital administration.

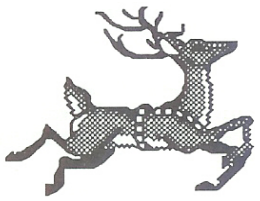
In response to media inquiries, the Sunshine Coast Regional Health Authority denied the closure was caused by budget cuts.

The authority said the association did not understand the situation and denied there would be any inconvenience to patients.

The association's information was obtained from publicly circulated memos advising staff of holiday rosters and Christmas arrangements.

The association maintains its objection to a three week closure of the facilities and the need for the hospital to force staff to take holidays *en bloc* to save money.

Christmas Party menu passes the taste test



Members planning to attend this year's Christmas Party meeting of the Redcliffe and Districts Local Medical Association can be assured of a very appropriate menu.

Vice president, Dr Geoff Hool and treasurer, Dr Judy Tucker, undertook the onerous task of visiting Rafael's Restaurant at Sandgate to decide which dishes would be served up to mark the Christmas theme.

Dr Hool says the result is that party goers will have the choice of three entrees, three main courses and three desserts.

Vegetarians will also be catered for if they ring the restaurant in advance.

The restaurant is BYO but the LMA with subsidise the evening with wine, beer and soft drinks.

The party is set down for Friday, November 29 from 7pm and tickets, at only $36 a head, are strictly limited to the first 70 in.

In the spirit to true dedication, Dr Hool decided to sample the fare with his wife Katie.

He says his favourite was the duckling terrine with pistachio nuts and a delicious chutney.

Katie adored the Chocolate Paradise with two sauces which she described as a gourmet's delight.

The party is open to LMA members and their spouse but tickets will be issued only on receipt of money by Dr Tucker at 2281 Sandgate Road, Boondall 4034.

PMS The Overlooked Syndrome

by Dr Moemen Morris

The vast majority of women (95%) seen in either general or gynaecology practice suffer one or more of premenstrual symptoms, premenstrual syndrome (PMS) occurs in about 5% of those women. Due to heterogeneity and large scale of PMS – related symptoms , diagnosis of this common condition is often overlooked.

According to the 10th international classification of disease symposium PMS is defined as recurrent psychological or somatic (or both) symptoms recurring specially during the luteal phase of the cycle and resolving by the end of menstruation and those symptoms must be sufficiently severe enough to disturb woman's normal functions.

An enormous range of symptoms has been described for PMS but the most common ones are depression, anxiety, tension, sad or depressed mood, increased appetite/food graving and the most common physical symptoms are abdominal bloating, headaches, breast tenderness, hot flashes or dizziness.

To make a diagnosis of PMS, symptoms should be recurring during luteal phase of the cycle, resolving by the end of menstruation, severe enough to disturb woman's normal function and have occurred in at least four out of six previous cycles

An extreme form of PMD is called PMDD(Premenstrual Dysphoric Disorder) in which symptoms of anger , irritability and internal tension are predominant.

The aetiology of PMS is poorly understood but their occurrence during luteal phase of reproductive age women and their absence before puberty ,after menopause or during pregnancy has led to the hypothesis that ovarian steroids particularly progesterone has a role in the Patho physiology of PMS .Imbalance of ovarian steroids may lead to disturbances in several neurotransmitters as Serotonin , Noradrenalin , Acetylcholine and Dopamine , Oestrogen for instance acts cumulatively as an agonist on Serotonergic function.

Several diagnostic tools for PMS has been suggested such as PSST (Premenstrual Screening Tool) DRSP(Daily Record of Severity of Problem) it is useful for the practitioner to ensure the recurrence and scale the severity of symptoms. Assessing gonadal steroids or gonadotrophins are of no clinical value but it is a good idea to test for thyroid function to exclude any underlying thyroid disorder.

SSRIs are good first line treatment of PMS as they found effective in alleviation of PMS symptoms in 70% of cases . Examples are Fluoxetine 20mg daily , Sertaline 50 -150 mg/daily , Paroxetine 20-30mg /daily or Citalopram 20-30 mg/daily. They can be used either during luteal and menstrual periods or throughout the cycle. If one SSRIs found ineffective ,you may try another one.

If still ineffective, first make sure that you are not missing a major psychological problem then you may try Non SSRIs such as Venlafaxine which is a good example as it inhibits both Serotonine and Noradrenaline uptake.

Ovarian suppression is a second line treatment of PMS in which they may be used by themselves or in conjunction with SSRIs , examples of steroid suppression are :

1. Oral Contraceptive Pills
2. Oestrogen implants or patches +progestogen rescue, a good practice example for that is the use of Oestrogen implant 50-100mg+insertion of Mirena.
3. GnRh analogues such as Gosarline 3.6 mg SC monthly for not more than six months (risk of increased BMD loss if used more than six month) their limited time of use and associated menopause like symptoms make them not an ideal treatment modality but they are useful if used to confirm the efficacy of surgery if tried preoperatively.

Surgery in the form of bilateral oophorectomy +/- hysterectomy should be kept as last resort if medical treatment fails to control symptoms of PMS.

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ABN 37 008 426 793

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

AMA CONDEMNS QUEENSLAND HOSPITAL DOCTOR CONTRACTS

The Federal AMA has condemned the Queensland Government decision to move all Senior Medical Officers in its public hospital system on to unfair and unbalanced individual contracts from 1 July 2014.

AMA President, Dr Steve Hambleton, said today the decision would have a dramatic negative effect on medical workforce numbers and patient access to care in Queensland, and warned that the changes could force doctors to move interstate or into private practice.

A meeting last night of the AMA Council of Salaried Doctors – which included senior public hospital doctors from around the country – resolved unanimously to condemn the proposed changes as a retrograde step that will harm doctors and patients in the Queensland public hospital system.

Dr Hambleton said that Senior Medical Officers in Queensland are currently covered by an enterprise agreement with Queensland Health.

"Successive enterprise agreement negotiations in Queensland have focused on the attraction and retention of Senior Medical Officers," Dr Hambleton said.

"They have helped to significantly lift the number of public hospital doctors in Queensland and have improved access to care for patients.

"The proposed new individual contracts will strip away key employment rights and undermine the progress Queensland has made in growing its public sector medical workforce.

"These draconian contracts will remove key protections such as fatigue provisions and rest breaks, limits on hours, access to unfair dismissal, dispute resolution, and grievance procedures.

"The changes are at odds with the rest of the country and raise genuine serious concerns that many Senior Medical Officers in Queensland will move interstate or abandon the public hospital system to work in private practice.

"Any loss of senior doctors from the public hospital system would make it harder to train the next generation of doctors entering the system to provide care for Queenslanders.

"If the Newman Government proceeds with these ideologically-driven changes, Queenslanders will soon find it much harder to access care in their local public hospital and they will experience longer waiting times.

"The AMA urges the Government to rethink these changes and to work with the AMA Queensland and the profession to reach employment arrangements that work best for the doctors, their patients, and the Queensland health system," Dr Hambleton said.

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24 October 2013

CONTACT: John Flannery 02 6270 5477 / 0419 494 761

Narangba Family Medical Practice

Job Vacancy

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

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

Contact: Dr Peter C. Stephenson, Mobile: 0403 151 602.

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

MAJELLAN MEDICAL CENTRE

Job Vacancy

A VR, GP is required for a Scarborough Beachfront, Non-Corporate Practice which is 30 minutes from Brisbane's CBD. The Accredited Practice has private billing facilities, modern equipment and has staffing of nine doctors and registered nursing support.

The Medical Centre has a Computerised Skin Cancer Clinic, ultrasound machine and operating microscope. Allied Health staff are also on site. A candidate who is fluent in English, Afrikaans, Dutch, German or French languages would be an advantage.

Contact: Angela De-Gaetano (Practice Manager)
Practice Location: Majellan Medical Centre, 107 Landsborough Avenue, Scarborough Q 4020
Practice Phone: (07) 3880 1444 **Practice Fax: (07) 3880 1067**



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"JUNIOR DOCTORS & MEDICAL STUDENTS URGE ACTION ON NATIONAL MEDICAL TRAINING PLAN"

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA Council of Doctors in Training (AMACDT) is urging Australian Health Ministers to agree to start work on a new national medical training plan when they meet in November.

The proposed national plan was one of the major topics discussed by junior doctors and medical students when the AMACDT met in Canberra over the weekend.

AMA Vice President, Professor Geoffrey Dobb, said that the need for a national plan was emphasised during AMACDT discussions about current bottlenecks for training positions for junior doctors, including for resident medical officer (RMO) positions in State and Territory health systems.

Professor Dobb said the recent experience in Tasmania, where it is understood that around 20 interns and RMOs have been unable to secure training places in 2014, highlights the training pipeline crisis facing Australia's future medical workforce and the community.

"All Australian governments are struggling to provide sufficient prevocational and specialist training places to match the very significant growth in medical school places since 2004," Professor Dobb said.

"The Health Workforce Australia (HWA) Health Workforce 2025 report last year warned that Australia needed to increase prevocational and specialist training places for doctors if the medical workforce is to meet future community need.

"The report also highlighted that Australia would face growing shortages in these essential medical training places unless more funding was provided, medical workforce planning was improved, and steps were taken to improve the coordination of the medical training pipeline.

"The AMA and the AMACDT support HWA proposals to establish the National Medical Training Advisory Network (NMTAN) and develop five-year national medical training plans.

"We understand these proposals will be on the agenda at next month's Health Ministers' meeting, and the AMA and the AMACDT urge all governments to adopt both proposals and start work on them straight away.

"A national medical training plan was first promised to be delivered by the end of 2011, and we are still waiting.

"The Australian community cannot afford any more delays with this important work," Professor Dobb said.

21 October 2013
John Flannery 02 6270 5477 / 0419 494 761
Kirsty Waterford 02 6270 5464 / 0427 209 753

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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.

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 AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

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Don't waste time! Join now!

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

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Rounded off with the End of Year Networking Meeting

Get your membership benefits! Socialise! Broaden your knowledge!

Dear Doctors

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

Annual subscription is $100.00. Doctors-in-training and retired doctors are invited to join at no cost. This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and/ or speakers are most welcome.

RDMA SUBSCRIPTION FORM – INTERNET PAYMENT PREFERRED

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

ABN 88 637 858 491

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

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

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

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

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

Practice Address: _____ Post Code: _____

Phone: _____ Fax: _____

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METHODS OF PAYMENT:

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

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

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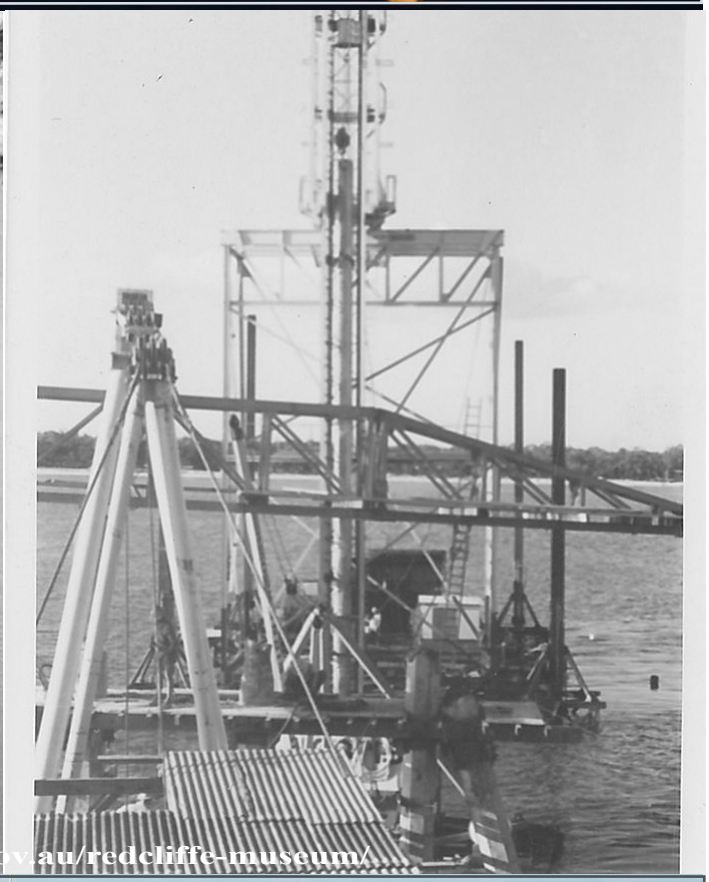

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