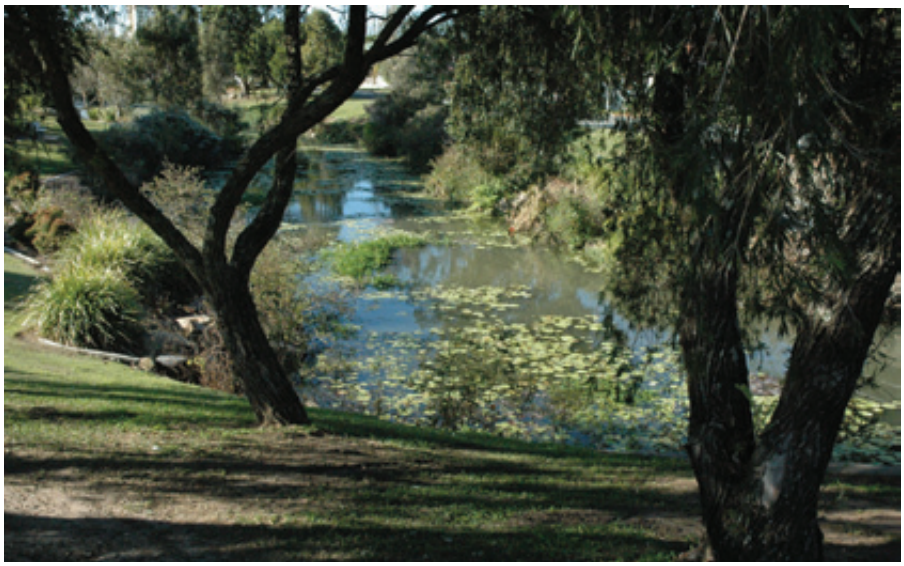
RDMA
REDCLIFFE & DISTRICT MEDICAL ASSOCIATION
Newsletter
September 2010



Humpybong

Humpybong near Redcliffe QLD. Australia is so called because when the British abandoned the area in favour of Brisbane they left behind their empty huts.

Aborigines called it Humpybong meaning dead humpies.

Continued Page 3 Historical Article and Pictorial Page 20

RDMA President's Message ... Dr Wayne Herdy

Welcome to the second issue of the new REDAMA Newsletter. The first issue was met with nothing but positive acclaim. This publication marks a significant step in the way that your Local Medical Association communicates with its membership. All those involved in its conception and birth are to be heartily congratulated.

An important aspect of this Newsletter is its LOCAL character. We welcome input from our members – articles of clinical or general interest, opinion pieces and letters to the Editor, whatever you want to communicate to your colleagues in our area.

Last month's meeting was our AGM. As you see, I was returned for a third year as President. We welcome a new Vice-President, and we welcome back our former Secretary and Treasurer. Inside you will find more information about the four office-bearers. They are your doorway into the workings of the Association – use them as your contact points whenever you have an issue that you think the LMA should be engaged in.

Once the Newsletter is well established, our next step into the 21st century will be to further improve our communications with our members by establishing a LMA website. Watch for this in the coming year.

One of my aims when I was first elected as President of REDAMA was to establish a Caboolture branch, to offer our Northern members the same services and opportunities as have been enjoyed for over 30 years by members in Redcliffe and Pine Rivers. Despite our best efforts, the interest shown by doctors in the Caboolture/ Morayfield area has not justified following that dream any further. It will be some time before REDAMA makes the effort to establish a Caboolture LMA.

The next venture to make REDAMA even stronger and more representative as YOUR local professional peak body will be to broaden our membership. All doctors are welcome to join. We traditionally attract those who work and/or live in the general area from outside Northern Brisbane to Glasshouse, and including all of Pine Rivers, but all doctors are potential members. We especially want to encourage our hospital-based colleagues and international medical graduates, two groups that we believe are most in need of a political voice and a collegiate professional family networking environment. Membership application forms are included inside the Newsletter.

Finally, I remind members of the social highlight of our calendar, the end-of-year networking function. This year we are returning to Sails on Sutton Beach, a very successful venue last year. Earmark Friday 26th November as your best opportunity to meet other doctors and their partners at an important networking event.

DATE CLAIMERS :

For all queries contact Tracey: (07) 3049 4429

Event: RDMA Meeting 14/09/10
Venue: The Ox, 330 Oxley Ave, Margate
Time: 7 for 7.30 pm
Sponsor: Sanofi Aventis Diabetes Team
Speaker: Dr Matt Rickard, TPCH, Department of Medicine
Topic: Basal and Beyond - Optimizing Insulin Regimes in Type 2 Diabetes

Event: RDMA Meeting 27/10/10
Venue: The Ox, 330 Oxley Ave, Margate
Time: 7 for 7.30 pm
Sponsor: Pfizer
Speaker: TBC
Topic: TBC

Event: Year End Networking Function 26/11/10
Venue: Sails Function Rooms, Suttons Beach Parklands, Redcliffe
Time: 7 for 7.30 pm
Sponsor: QML Pathology

CONTACTS:

President: & AMAQ Concillor:	Dr Wayne Herdy Ph: 5476 0111
Vice President:	Dr Kimberley Bondeson Ph: 3284 9777
Secretary:	Dr Ken Fry Ph: 3359 7879
Treasurer:	Dr Peter Stephenson Ph: 3886 6889
Hospital Liaison:	Ms Kerryn Allen Ph: 5433 8888
Newsletter Editor:	Dr Wayne Herdy Ph: 5476 0111
MBGPD CEO:	Dr Paul Sutton Ph: 3284 5155
Meetings Convenor:	Ms Tracey Jewell Ph: 3049 4429

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RDMA Newletter Publisher, Photographer, Journalist
Please email (preferred) any correspondence to:

Email: RDMAnews@gmail.com
Website: http//www.rdma.org.au
Mail: RDMA, PO Box223, Redcliffe 4020
Fax: (07) 5429 8407
Mobile: 0408 714 984

OCTOBER NEWSLETTER 2010

The 30th September 2010 is the timeline for ALL contributions, advertisements and classifieds.

Please email the RDMA Publisher at RDMAnews@gmail.com or Fax: (07) 5429 8407
Website: http//www.rdma.org.au

THIS NEWSLETTER

Thank you to the following members for their contibutions:
- Dr Philip Dupre's article on "The Origin of Life".
- Dr Vern Healzewood's Letter to the editor
- Dr Mal Mohanlal's article "Consumer Laws & Doctors"

New members: accepted at an RDMA Committee meeting, are asked to introduce themselves to the Association via the monthly newsletter. We look forward to introducing any new members in the next addition.

INSIDE THIS ISSUE:

Humpybong

Historial Article:

THE PHOTOGRAPHS IN THIS ISSUE ARE OF HUMPYBONG CREEK AT THE WESTERN ENTRANCE TO REDCLIFFE:

Redcliffe was once a small seaside retreat 40 km north of Brisbane. When the Hornibrook and Houghton Highways linked Brighton, an outer Brisbane suburb, to the Redcliffe peninsula, then Redcliffe became much more accessible and grew as part of Brisbane's suburban sprawl.

The area was first visited by Matthew Flinders in July 1799. He spent 15 days in Moreton Bay, landed and named Red Cliff Point on 17 July. It was not until 1823 that John Oxley, on instructions from Governor Brisbane to find a suitable place for a northern convict outpost, visited Moreton Bay. It was on Oxley's recommendation that Red Cliff Point was chosen for the penal colony.

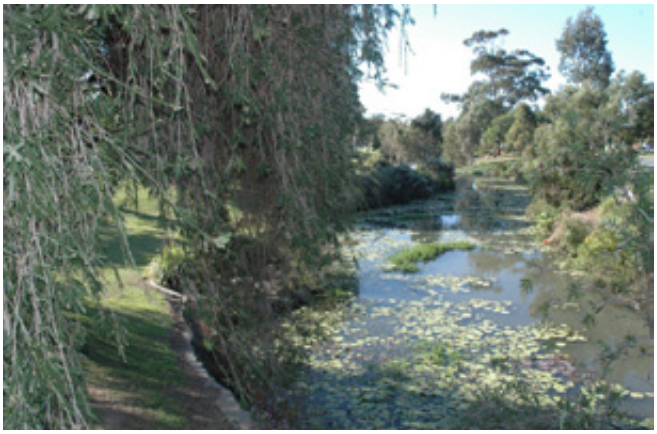
On 24 September that same year the brig Amity brought officials, soldiers, their wives and children, and 29 convicts to Redcliffe. Three children, the first European children born in Queensland, were born in September and November 1824.

The settlement progressed well with temporary huts being built for the soldiers, their wives and children, and the convicts. Gardens were dug and vegetables planted. However the death of Felix O'Neill in March 1825 combined with Aboriginal attacks, hordes of mosquitoes and the lack of safe anchorage facilities, led to the settlement being moved in the middle of 1825 from Redcliffe to the banks of the Brisbane River.

A few buildings were left standing at Redcliffe and it is claimed that the local Aborigines, with a rather nice sense of irony, called the houses 'oompie bong' meaning 'dead house'. The name stuck and the Anglicised 'humpybong' was applied to the whole of the Redcliffe Peninsula.

During the short life of the convict settlement a store, prisoners" barracks, a kitchen, well, whipping post (no good convict settlement could be without one), gaol, guard room, brick kiln, soldiers barracks and commandant's house were all constructed. The stores and the main landing place were located where the Redcliffe Jetty now juts out into Moreton Bay. More details on the early history are contained in the excellent Redcliffe 1824 and Matthew Flinders in Moreton Bay 1799 both of which are available from the Redcliffe Museum.

It was not until the early 1860s that the Redcliffe area was opened up for agricultural purposes. Over the next



70 years it grew slowly. The first school was opened in 1876, hotels were built at Woody Point, Redcliffe and Scarborough in the 1880s, the Woody Point Jetty was completed in 1881, the Redcliffe jetty and Post Office were built in 1885 and Garnet & Natone's steamers from Brisbane started a regular service in the 1880s.

In 1908 a publication the Souvenir of Humpybong (it can be obtained from the Redcliffe Historical Society) sang the praises of the peninsula: 'The exhilarating climatic conditions of Redcliffe, Woody Point and Scarborough cannot be too highly praised. They are little paradises set in the silver sea, where you can breathe God's glorious oxygen and thrill with delight to be alive.

'Excellent as summer resorts, their chief attractions are their beautiful mild winters...those who desire a change of scene and who are in search of health and renewed youth to visit Humpybong and sojourn there at all seasons of the year.'

Redcliffe remained an isolated retreat until 1935 when one of the engineering marvels of Queensland, the Hornibrook Highway, was built. The Hornibrook Highway stretches 2.74 km across the mouth of the Pine River and Hay's Inlet and is the longest road bridge in Australia. It linked Redcliffe to Brisbane and, particularly after World War II, was instrumental in the rapid growth of the Redcliffe area. By 1969 some 20 300 vehicles were using the bridge every day and with a single lane either way just one breakdown caused chaos. Consequently in 1974 it was decided to build a second bridge. It was completed in 1979. It has 99 spans and a total of 400 beams. The longest pile was driven 38 metres before reaching sandstone.

Today Redcliffe is one of the popular outer city beachside retreats for Brisbane residents. It is pleasant and thriving centre which officially became a city in 1959.

Source: Sydney Morning Herald:
http://www.smh.com.au/news/Queensland/Redcliffe/2005/02/17/1108500203689.html

Redcliffe: Interesting historic settlement in Brisbane's northern suburbs.

Please refer to Page 20 for Humpybong's Pictorial.

moreton bay
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INVITATION

MORETON BAY GENERALPRACTICE NETWORK LTD'S

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ANNUAL GENERAL MEETING

Featuring Guest Speaker

Kay Danes

Bestselling author, humanitarian and renowned public speaker

Kay will inspire you as she recounts her nightmare in Laos held captive for 10 months by corrupt government officials

Date:
24 September 2010

Time:
6.00pm for registration and drinks

Place:
North Lakes Golf Club, Bridgeport Drive, North Lakes

RSVP:
10 September 2010
07 3284 5155

CHANGES TO CLASSIFIEDS

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

Classifieds will be published for a maximum of three placements.

Classifieds are not to be used as advertisements.

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

REDCLIFFE & DISTRICT 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

The RDMA Annual General Meeting at The Golden Ox, Redcliffe (above). RDMA Members attended to elect their new Executive Team.

See our new Executive Team's profile on pages 12 & 13

Clockwise starting from the right bottom hand corner:
Photo 1: Dr Wayne Herdy with the speaker of the night, Dr Geoff Harding.

Photo2 : Dr Tom Moore in the blue hat,

Photo 3: Drs Ken and Margaret Fry, Dr Peter Stephenson and Ms Tracey Jewel.

Photo 4: Drs Andrew Butler, David Tan and Warwick Marx.

Photo 5: Drs Max Wilson and Dr Wayne Herdy.

Photo 6: Ms Tracey Jewell.

Photo 7: Dr Geoff Harding Topic Speaker "Muscular Skeletal Medicine" National Pain Strategy.

Photo 8: Drs Bernard Chan, Kimberley Bondeson and Pravin Kasan.

Photo 9: Drs Bram Singh and Jai Raj.

Photo 10: Mundiparma personnel Hospital Specialist: Dale King presenter and Field Manager Tamara Knight.

THE ORIGIN OF LIFE

Dr Philip Dupre

Reprint: Dr Philip Dupre tendered an article which was printed in the previous newsletter, unfortunately the final article contained a number of typos for which the editoral staff accept full responsibility. Dr Dupre has kindly allowed us to reprint his article with all typos amended. We hope you enjoy the article and the associated letter to the editor too.

The generally accepted theory is that life originated when complex organic compounds were formed by chance out of an inorganic prebiotic soup over billions of years. These compounds came together by chance to form a complex life form capable of reproducing itself, and all this at exactly the right temperature and time.

The basic requirement of any life form is that it is able to reproduce itself. The only substance that can do this is DNA. DNA is like a very long twisted rope ladder with billions of rungs. Each rung is made up of a pair of only four nucleic bases thymine (formula $C_5H_6N_2O_2$), cytosine, guanine and adenine. These pairs are attached each side to alternating units of phosphate and deoxyribose sugar ($C_5H_{10}O_4$). A gene consists of thousands of these rungs and it is the precise sequence of the base units that makes up its specificity. For example one gene is the pattern for one polypeptide chain and the combination of different polypeptides makes a specific protein or enzyme. DNA works in a similar manner to a computer using a quaternary instead of a binary code.

The protein Haemoglobin consists of 19 different amino acids, 574 in total. If just one of these is out of place then it will not function. It has been estimated that the odds against this protein being formed by chance is 10^{500}. Bearing in mind that the number of atoms in the universe is about 10^{66}, the random formation of haemoglobin is a very unlikely event.

Every one of the 60 trillion cells in the human body contains enough DNA information to reproduce another complete human being or clone. Stem cells form themselves into multiple organs of exactly the right size. The control for this sequence of events is too complex to be understood.

If the lengths of the DNA of a single cell were put end to end it would stretch about 2 metres. Or by comparison, if the cell were the size of a soccer ball it would stretch 200 kilometres.

This entire length is kept tidy in the cell nucleus by being wound around histones. When the cell divides, and 60 billion do so in our bodies every minute, the DNA ladder splits down the middle under the influence of the enzyme DNA polymerase, (where did this come from in the original DNA Molecule?), at the rate of about 8,000 rpm (the DNA is coiled into a helix). Each strand then attracts new molecules to reform a complete helix with the help of another enzyme DNA Ligase.

It is estimated (Professor Ashley Montagu), that if the DNA from a single cell of every individual on the earth today were put together it would occupy a space no larger than a single aspirin tablet. The simplest form of DNA complex is a virus but for a virus to reproduce it needs to enter a living cell to utilise energy from mitochondria and the protein producing ability of the host cell, it is unable to reproduce on its own.

There is a complex mechanism within the DNA of every cell that corrects mutations. The genes of fruit flies were manipulated to produce flies with no eyes. When these were interbred their offspring also had no eyes. But after several generations eyes started to reappear due to this fail-safe mechanism, reverting back to a normal fly.

Dr Francis Crick, an atheist and co-discoverer of the structure of DNA admitted that it was impossible for DNA to have been spontaneously developed, he proposed that it must have come from outer space, (which in a sense it did).

Charles Darwin in his latter years wrote: "Why, if species have descended from other species by fine graduations, do we not everywhere see innumerable transitional forms? Why is not all nature in confusion, instead of the species being, as we see them, well defined? But, as by this theory innumerable transitional forms must have existed, why do we not find them embedded in countless numbers in the crust of the earth…… I have asked myself whether I may not have devoted my life to a fantasy….. I am ready to cry with vexation at my blindness and presumption……If it could be demonstrated that any complex organism existed which could not possibly have been formed by numerous, successive, slight modifications, my theory would absolutely break down."

Lastly to quote the NLT Bible, Romans 1:19, 20 "They know the truth about God because he has made it obvious to them. For ever since the world was created, people have seen the earth and the sky. Through everything God made, they can clearly see His invisible qualities, His eternal power and divine nature and so they have no excuse for not knowing God.

Bibliography

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Dr Chuck Missler, Koinonia House, 2004, Cosmic Codes

Grant. R. Jeffrey, Waterbrook Press, 2009, Creation

Letter to the Editor

Dr Vern Heazlewood
(Consultant Physician)

I read with interest the articles in the August newsletter by Drs. P. Dupre and A. Houston. It is really a matter of 'What is truth?' and 'How is truth verified?' If religion is based on myth, tradition or cleverly constructed ideologies, then it is 'play' (as Dr. Houston says) or a merely intellectual exercise. But what is actually true and verifiable?

Dr. Dupre exposed some of the evidence (molecular design of DNA) for the profound basis of living matter that is observable. Whatever sphere one may consider, be it cosmological, geological, biological or psychological, there is a vast evidence of complex, orderly structures and frameworks which cannot be foolishly dismissed as being due to the impersonal, plus time plus chance. Sir Fred Hoyle (of Big Bang theory fame) has stated that as one goes back in time, a point is reached where the universe is 'shrunk down to nothing at all' (in 'From Stonehenge to Modern Cosmology'). That is, according to the Big Bang model, the universe began to exist, ultimately arising out of nothing. What is observable in all that we see and know, therefore, represents an intervention of profound magnitude.

Following this cosmological evidence, we have historical evidence although data on origins is prehistorical. However, about AD 30, one is quoted as saying 'Father, glorify me in your presence with the glory I had with you before the world began'. This historical Jesus of Nazareth , who claimed to be the Truth, was either a liar, lunatic or Lord. Various Jewish and non-Jewish writers (Josephus, Pliny the Younger, Tacitus, Suetonius) have not disclosed any evidence that would discredit his integrity or sanity. Rather, this one of whom it was written, was the 'Word, was God, was with God in the beginning and through him all things were made' (John, about AD 85). This is authentic historical evidence of the Divine Being (God) revealing himself to man, validating his deity by rising to life after being murdered and now claiming to be the maker of all things.

The third line of evidence is metaphysical and psychological. We have unique features of personality, creativity, ability to love and worship, innate moral sense, verbal communication and fear of ceasing to be. It is understandable that we, as finite beings, ponder about an infinite reference point, if we are to have any meaning for life. Even the ancient Greek poets acknowledged 'in him we live and move and have our being' (Epimenides, in Cretica, c. 600 BC) and 'we are his offspring' (Aratus, c. 315-240 BC, in Phaenomena). Man can attempt to create his own infinite reference point (as in religion) or he can accept the Infinite Reference Point stepping into human experience in relationship (as in Christianity). The infinite personal God has identified and communicated with us and has provided the way for relationship with him to occur. The reality of this relationship is stunning evidence and it also gives a cohesive understanding of all that is and a conviction and power to love and correct injustice. This allows the ultimate imperative of practising medicine. With help from above honouring God, one seeks to rescue, in love and without prejudice, his fellow creature man from disease and suffering, attempting to overcome the ravages of evil in this world.
07/09/10

"Consumer Laws & Doctors"

Dr Mal Mohanlal

It is time the medical profession questioned its role in society and the direction we are heading. Clearly politically inspired consumer laws are negatively influencing the practice of medicine and here we are all sitting like ducks waiting to be shot.

There was not even a whimper from the medical profession in the recent case of Dr Jayant Patel where a doctor who had no intention of harming or killing his patients, was tried and convicted of manslaughter. Surely we as a profession should have been expressing strong outrage and objection to such a charge. How can a person of this calibre, who undoubtedly possesses so much skill, intelligence and knowledge, and has devoted all his life to helping people get better, be classified in the same category as a violent person who goes about bashing a person to death?

As doctors we have a responsibility to straighten out people's distorted perceptions, and not go along with them. With the consumer laws and the way they are applied, people are being led to believe that they are consumers of health. As a result they put us in the same class as a motor mechanic who fixes their car. They are ready to sue the mechanic for faulty repairs. But repairs job done on a car is entirely different the from the repairs job done on a human body. While the job done on a car is entirely dependent on human element from manufacture to parts and repairs, the job done on a human body is mostly if not entirely dependant on the person's own healing power and not on the doctor.

People should be told that a consumer item is something you trade, dispose of or replace. The human body is not consumer item. It cannot be replaced, only certain parts can be. So it is not like a car that can be replaced like a consumer item. It is a delusion to think of the human body as a consumer item.

Physical or mental health is therefore always a personal responsibility. A doctor can only advise, guide and prescribe. Eventually it is the person's own effort and self care twenty four hours a day that results in good or bad health for that individual. Health is therefore not a consumer item that is to be exploited in the same way as other consumer items.

Hence as doctors we can only do our best to help a person get better quickly. Most doctors like me, wish we could wave a magic wand and instantly cure our patients and most surgeons I am sure would want a hundred percent success rate when they operate.

But curing a patient is not that simple. It involves so many factors. They are physical and mental. The most important is the individual's auto-immune system which is the system that bears the brunt of all these factors. If your immune system shuts down, you are gone. No matter how many doctors you may have around you, no one can save you. This is why is the healing process in every individual is never the same. Each individual will respond differently.

Recent advances in medical science and technology have enabled doctors to produce so called miracles of modern medicine. They have led the people to believe that doctors can work miracles. Now the public expectations of outcome of medical treatment have become so unrealistic that litigation is the order of the day. They do not understand what personal stress a doctor has to go through when there is a medical mishap.

Hence doctors are now practising defensive medicine. Tests and investigations are being ordered routinely in hospitals and private practice and the cost of medical care is sky rocketing. Not only that but people in nursing homes who are vegetating and confined to bed are being prescribed antibiotics etc to prolong their miserable life in the name of humanity and for fear of litigation. More increase in pharmaceutical costs.

It is time the medical profession told the public and the legal profession that there are no guarantees in medicine. There is no such thing as a preventable accident. All accidents are preventable, but only in hind sight. Medical mishaps will occur because we are all human and because of Murphy's law. If society wants to compensate the so called 'victims' of medical mishaps, they should come up with a different system of compensation without dragging the hard working doctors down. If we do nothing to change the present laws, everyone will be a loser. Deskilling of doctors will continue and they will just become referral clerks who do not want to take on any responsibility.

The term 'preventable accident' distorts our perception and judgement. Is our legal system aware of this fact? It is the same thing as calling a pregnant woman a 'pregnant virgin'.

10 August 2010

RBS Morgans

Appointment of RBS Morgans as Co-Manager to the proposed initial public offering of QR National

QR National - Proposed Initial Public Offering

On 8 December 2009 the Queensland Government announced its intention to offer for sale, through a public listing, the coal and freight business of QR Limited - to be called QR National. We are delighted to inform you RBS Morgans has been appointed Co-Manager for the proposed initial public offer (IPO) of QR National.

Subject to the Queensland Government's asset sale process, it is anticipated that QR National will apply for listing on the Australian Securities Exchange (ASX) during the final quarter of 2010. If successfully listed, it is expected to be one of the 50 largest companies on the ASX.

QR National is Australia's largest rail freight haulage business by tonnes hauled, with over 145 years of experience. QR National is focused primarily on large, heavy-haul rail tasks such as the transportation of coal, iron ore and other minerals, agricultural products, general freight and containerised freight. QR National also operates and manages 2,300 kilometres of dedicated and purpose-built, heavy-haul rail infrastructure in the Central Queensland Coal Network (CQCN) and provides a range of specialised rail infrastructure, maintenance and manufacturing services.

The following materials prepared by QR National provide a summary of information relating to QR National:

Short video - "About QR National, from the CEO"
http://www.qrnational.com.au/Pages/Home.aspx

Short video - "Our Diverse Business Operations, from the CEO"
http://www.qrnational.com.au/Pages/Home.aspx

QR National Quick Facts Booklet
http://www.qrnational.com.au/MediaCentre/InformationSpeeches/Documents/QRNational_QuickFacts.pdf

RBS Morgans is excited to be part of the syndicate working on the proposed QR National IPO and would encourage you to learn more about QR National. RBS Morgans Redcliffe is the only Stockbroker in the Moreton Shire.

Kind regards

RBS Morgans – Redcliffe ph 3897 3999

Investors should consider the Offer Document (when available) in its entirety before deciding whether or not to apply for QR National shares. Anyone that wishes to acquire QR National shares will need to complete the application form that will be in or accompany the Offer Document

ADVERTISING

RDMA Newsletter advertising guidelines stipulate that the amount of advertising is not to exceed 25% of the newsletter.

If you are interested in advertising please email RDMAnews@gmail.com for a price list for all size advertisements. Discounts are available for ongoing advertisements.

MEDICAL MOTORING

with Doctor Clive Fraser

Motoring Article #74

BMW 320 TOURING
"Mid-life Make-over"

Cosmetic surgeons make a tidy sum from procedures that are aimed at maintaining a youthful appearance.

Of course it helps to start off with good genes in the first place, but why not inject some collagen or Botox, and a snip here and there will help to smooth out all those wrinkles.

As a psychiatrist I've seen some really bad examples of patient selection with obsessive compulsive disorder and body dysmorphic disorder generally associated with continuing aesthetic dissatisfaction.

And cosmetic surgeons need to take note that a blank staring appearance does make it much more difficult to assess a patient's affect.

Hoges is a good example of this with his face-lift making it hard for me to judge his response to the $150 million tax bill.

Car makers also know the value of sprucing up their model line-up and with a seven year model cycle it was time for some tinkering on BMW's 3 Series.

The main up-grade was tweaking the already outstanding 2 litre diesel power-plant.

Power has gone up from 130 kW to 135 kW and torque has also improved from 350 Nm to 380 Nm, and all this from an engine which is physically the same.

Economy has also improved by 4% to 5.4 l/100Km.

The Executive is now replaced by the Life-style model and the popular Executive Innovations package is now called Exclusive Innovations.

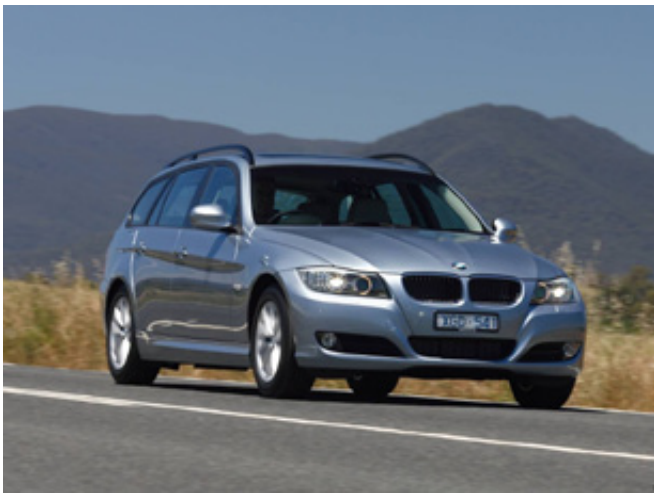
This pack costs $4500 and includes GPS and Xenon headlights with an automatic high-beam feature.

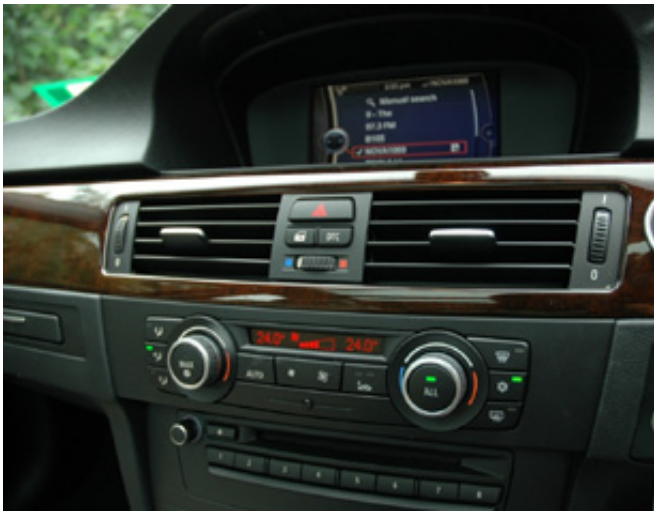
The headlights will dip when an on-coming car or streetlights are detected and it works just as well as my left index finger.

A useful feature on the inside of the Beemer is programmable radio buttons.

These can be used as a speed dial for phone numbers and can be pre-set for GPS locations.

Oh, and by the way they can also be used to select a radio station.





At $3200 the wagon option is not cheap, but it makes so much more sense for a family who have things to lug around and way more sense than opting for a bulky SUV.

On the road I still don't like those run flat tyres which make the ride noticeably hard.

I'd advise against opting for the 18 inch wheel option unless you've got a particularly well-padded rear end as those lower profile tyres only further aggravate the harsh ride.

And by the way those 18 inch run-flats are $750 each and don't last as long as ordinary tyres.

So BMW motoring was never going to be cheap.

Even the oil is $25 per litre and is only available from the dealer unless you're prepared to buy it in a 20 litre drum.

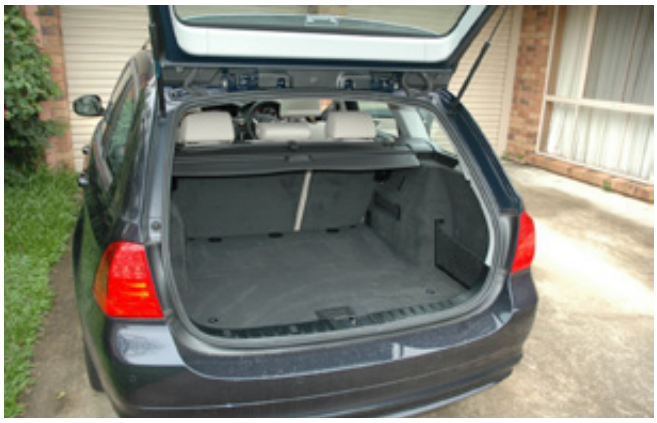
But it is hard to go past the quality and durability of this outstanding car and as a replacement for my beloved 13 year old Volvo V70 the BMW 320d Touring is definitely on my list.

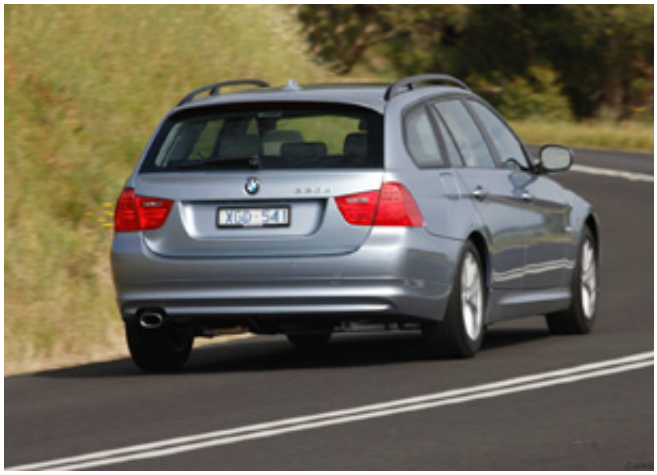
BMW 320 Touring

For: A quality family wagon.
Against: A colleague told me that the 320d was a hairdresser's car.
This car would suit: Me.
Specifications:

2.0 litre 16 valve 4 cylinder turbo-diesel
135 kW power @ 4,000 rpm
380 Nm torque @ 1,750 rpm
7.9 secs 0-100 km/h
6 speed automatic
5.4 l/100 km (combined)
$62,300 + ORC for the base Life-style model without any options.
Definitely made in Germany

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





REDCLIFFE & DISTRICT MEDICAL ASSOCIATION INC

New Executive Team

PRESIDENT
Dr Wayne Herdy

Wayne Herdy has worked in General Practices from Petrie to Caboolture virtually continuously for over 30 years, and started attending REDAMA meetings shortly after its inception.

His general practice work has a heavy leaning towards three unpopular areas of practice – aged care, drug and alcohol addiction, and indigenous health. Pursuing the third of those interests, he travels to remote aboriginal communities for two weeks every two months, and has accumulated a fascinating collection of photographs of parts of central Australia not known to the tourist traffic.

He is one of the best known medical politicians in Queensland. During his six years as AMAQ (State) Branch Councillor and six years as AMA (Federal) Councillor, he sat on up to ten committees at once, while also serving as President of one LMA and Vice-President of another. Apart from his obvious conviction that the AMA is the only body to properly represent the medical profession at all levels of government negotiations and getting messages to the public, he strongly believes that Local Medical Associations bring grassroots members of the profession together in a way that no other organization can. He is passionate about the power of LMA's to bring colleagues together socially, to network, and for educational and political information sharing.

Wearing his other hat as a member of the board of the local Division of General Practice, he hopes to bridge the gap between the political ideology of the AMA family and the often conflicting ideology of the world of Divisions. Even though the two professional families often are at loggerheads in their principles, he believes that ultimately at the level of medical practice they are both aiming to get the best outcomes for doctors and patients.

In his Presidency of REDAMA over the past two years, he has worked to develop a Caboolture branch of REDAMA, to bring to the northern end of our territory the same quality of meetings that have been long enjoyed on the Redcliffe peninsula. He is particularly proud of the new look Newsletter, which has returned to its early concept of being a truly local product. Over the next year, he hopes to expand the communication tools of REDAMA to include a website. He particularly wants to see membership grow, hoping to bring young graduates into the fold of what he sees as a wider medical professional family.

VICE PRESIDENT
Dr Kimberley Bondeson

Dr Kimberley Bondeson is a full-time General Practitioner in Private Practice in Margate, on the Redcliffe Peninsular. She is an experienced General Practitioner, whose experiences which include working for five years in rural and remote Queensland.

She has a special interest in Aviation Medicine and has recently joined the AMAQ Council of General Practice, representing the Greater Brisbane Area. She participates yearly in the AMAQ Annual Conference which is going to be held in Boston, September of this year.

Kimberley is looking to expand the membership of the Redcliffe and District Medical Association (RDMA) with a particular interest in recruiting younger members and advancing the professional interest of doctors and the health of the community. In particular she wants to develop a plan to involve younger doctors, interns and registrars who work in the local surrounding hospitals, at Redcliffe and Caboolture.

Kimberley would also like to see a webpage developed to help with access to the RDMA, and to bring awareness to the younger doctors as to the benefits of belonging and becoming involved with their local RDMA. She would like to hear from some of the younger doctors of their experiences and any difficulties they maybe facing. She feels that one of the major benefits of belonging to the RDMA is the sharing of different experiences, clinical and otherwise, between senior and junior colleagues. With the large influx of new graduates coming through, and the resulting pressure this will put on training places, some new graduates are going to feel that they are 'left out in the cold'.

There is also a large group of International Medical Graduates, who will benefit from membership of RDMA, as they do not have the first hand knowledge of the local medical system or structure.

Kimberley wants to encourage regular attendance to RDMA dinner meetings, which are held on a regular basis. Kimberley is delighted on becoming a part of the new Executive of the RDMA and with these challenges ahead; she is looking forward to becoming more actively involved in her RDMA responsibilities.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION INC's
New Executive Team

TREASURER
Dr Peter Stephenson

Picture: At Watts Bridge Airfield, Toogoolawah, practising what he preaches in relation to sun exposure.

Born in Livingstone, Northern Rhodesia, now Zambia in 1951. He moved soon after to Lusaka for a few years, followed by Salisbury (now Harare) Southern Rhodesia (now Zimbabwe), for his school education.

He left there for the UK where he completed his high school education in Edinburgh, Scotland and attended St. Mary's Hospital Medical School, London University, qualifying in 1974 with M.B.B.S.(Lon.) L.R.C.P.(Lon), M.R.C.S. (Eng) degree and Diplomas. He complted his Hospital internship in Medicine and Surgery at Black Notley Hospital near Braintree Essex England.

In early 1976, he migrated to New Zealand with his wife Gabrielle and two children to Tokoroa Hospital as Senior House Officer for rotations in Casualty, Obstetrics and Gynaecology, Medicine and Surgery.

In January 1977, he and family migrated to Australia for a three month GP locum in Grafton NSW followed by General Practice in Strathpine, Queensland. Here he opened his solo practice in mid 1977 also in Strathpine. A move to Narangba in 1986 followed, now with four children where he opened another practice beside his home and relinquishing Strathpine.

He moved the practice to its existing premises in 1993.

Interests include:
Medical Information Technology and first Beta Tester for Medical Director, the most popular desktop program on GP's desks.

Flying sailplanes at Caboolture Gliding Club and now an Instructor. Keeps fit riding a bicycle with his wife Gabrielle. They are now proud grandparents of five children.

One of his goals is to be a research and development watchdog. He is also RDMA'S resident Information Technology Reference Person on information technology matters.

SECRETARY
Dr Ken Fry

After graduating from the University of Queensland in 1960, Dr Fry started work at the Royal Brisbane Hospital and later moved to the Royal Women's Hospital, Melbourne.

His training in Obstetrics and Gynaecology continued in Walton Hospital, Liverpool, UK after gaining Membership of the Royal College of Obstetricians and Gynaecologists, London.

Returning to Australia in 1970 he established a Private Practice on Wickham Terrace, Brisbane, and later was appointed to a VMO position at the Royal Women's Hospital.

During that time he was the Royal Women's Hospital representative on the Postgraduate Education Committee at the Royal Brisbane Hospital.

In 1998, he was appointed as a Senior Examiner in the Australian medical Council, a position he still holds.

On retiring from private and public practice in 2000, he has been employed in a relieving position at the Royal Women's Hospital, and since 2002 have been tutoring second year students in the Graduate Medical Course of Queensland University.

A longstanding member of both the Northside Local Medical Association and the Redcliffe and District Medical Association, he has served as chairman, secretary and treasurer in the former and continues to be a committee member, while in the latter he has served as secretary for 3 years.

He is committed to continuing medical education and to this end he is a regular attendee at the associations' monthly meetings. In this way, he makes contact with the members and participates in discussions at question time. He has no immediate thought of leaving the association.

AMAQ & FEDERAL COUNCILLOR REPORT - *Federal Election*

Wayne Herdy, North Coast area representative, AMAQ Branch Council, Queensland area representative, AMA Federal Council.

With the election result still deadlocked as I write, and my publisher hounding me for the deadline, let's forget about politics and now for something completely different (to steal a line from Monty Python).

My special role in the AMA is in aged care. Some trumpet-blowing is called for here, because I was flattered to be appointed as the Chair of the (Federal) AMA committee for Healthy Ageing. I have for some years been a member of the AMAQ (State) Aged Care Coalition. I have had more than a few moments to reflect on what is right and what is wrong about aged care, especially residential aged care.

So in this column I am going to put on my fortune-teller's costume and foretell the future of residential aged care in Australia. I hasten to add that what follows is my personal opinion. It is not AMA policy. I am also aware that the Productivity Commission is conducting an enquiry into aged care in Australia – the Federal AMA put together a team of experts plus myself to talk to the Commission. What follows is not based on anything that the commissioners said to me.

FIRSTLY. What is residential aged care going to look like by the time I am there as a patient? Residential aged care provides four things – a building, hospitality (food and laundry and so on), personal care (bathing and entertainment), and nursing/medical care.

I think the buildings will be different. Dormitory wards will be non-existent. Two-bed wards will be infrequent. Most wards will be single bed with ensuite. I would love to see a motel-style room that older or disabled people go into very early, and stay a long time, but the values reflected in that are arguable. I do not think that the hospitality component will change much, and the personal care bit will be improved only a little but smarter technology.

The big difference will be in nursing care. We are trending towards lower-skilled or unskilled carers, away from registered nurses. Medical care is already a footnote, an afterthought to what nursing homes provide. The nursing home owners regard doctors as a necessary evil but not necessarily as part of the whole aged care process. That philosophy is reflected in government policies – doctors and their contribution to aged care are a totally different budget line. What I want the AMA to do is to ensure that doctors become central to aged care.

SECONDLY. What is going to be the doctor's role? The answer to this question depends on whether the government policies lean towards one end of two extremes. At one extreme is the scenario where people entered residential aged care early in their dependency, stay in an ageing-in-place environment for many years, and the level of care they receive gets escalated as their dependency increases. At the other extreme, patients will stay in the community as long as possible, only going into nursing homes when all else fails, and will be effectively short-stay terminal patients in what will essentially be community hospices. As the real-life nursing homes trend more towards the latter extreme, doctors will become increasingly important in medication management and directing palliative care. There are workforce implications that are not without a ready-made solution. As the numbers of medical graduates crescendos, there will be more and more new GP's who seek out aged and palliative care as a first choice, a challenging career option.

THIRDLY. How are we going to pay for all this? Inevitably, there must be increasing user-pays mechanisms. I can see only two that will work – bonded positions or compulsory insurance. Bonds will become more common than fully-funded beds. This is fraught with problems which do not have nice solutions. This is unsavoury to politicians. They do not want to go down in history as the government that forced old people to sell the family home to go into a nursing home. There will be increased dodging of the liability – adult offspring will sell the family home, divert the assets, and then claim that the parents have no assets. However, if a bonded place offers value for money, then bonds can be sold as palatable. At present, a wealthy person who pays a bond ends up in the same sort of room with the same services as an impecunious public patient in a fully funded place. To the wealthier residents, this is an inequity – unless they can be given something more than comes standard with the publicly-funded room. It looks better again if patients go into nursing homes early with the expectation of a long stay – then they are selling one private residence to purchase a different style of down-sized residence, not quite as bad as selling the family home to buy a bond in a nursing home.

Compulsory insurance is probably inevitable. The baby boomers were forced to pay their compulsory superannuation (to buy their own retirement funding) while paying taxes (to pay for their parents' retirement funding ie a pension). Similarly, the gen X and gen Y will probably have to purchase compulsory retirement "health" insurance as part of their superannuation package, while paying taxes to subsidize their parents' nursing home costs. Before you go off and slash your wrists, a quick disclaimer: the performance of my investment portfolio during the global meltdown establishes indelibly my credentials as one of the all-time worst possible futurologists. But the aged care problem is one which no government in the Western world has yet come to grips with. The clock is ticking ever faster. I repeat, the above is my personal opinion, not AMA policy. Exception: AMA does have a policy seeking to force nursing home operators to engage medical care as a central element of aged care.

Interesting Tidbits

NATTY MOMENTS:

PUNS FOR THOSE WITH HIGHER IQS I

- Those who jump off a bridge in Paris are in Seine.
- A man's home is his castle, in a manor of speaking.
- Dijon vu - the same mustard as before.
- Practice safe eating - always use condiments.
- Shotgun wedding - A case of wife or death.
- A man needs a mistress just to break the monogamy.
- A hangover is the wrath of grapes.
- Dancing cheek-to-cheek is really a form of floor play.
- Condoms should be used on every conceivable occasion.
- Reading while sunbathing makes you well red.
- When two egotists meet, it's an I for an I.
- A bicycle can't stand on its own because it is two tired.
- What's the definition of a will? (It's a dead give away.)
- Time flies like an arrow. Fruit flies like a banana.
- In democracy your vote counts. In feudalism your count votes.
- She was engaged to a boyfriend with a wooden leg but broke it off.
- A chicken crossing the road is poultry in motion.
- If you don't pay your exorcist, you get repossessed
- With her marriage, she got a new name and a dress.
- The man who fell into an upholstery machine is fully recovered.
- You feel stuck with your debt if you can't budge it.
- Local Area Network in Australia - the LAN down under.
- Every calendar's days are numbered.
- A lot of money is tainted - Taint yours and taint mine.
- A boiled egg in the morning is hard to beat.
- He had a photographic memory that was never developed.
- A midget fortune-teller who escapes from prison is a small medium at large.
- Once you've seen one shopping centre, you've seen a mall.
- Bakers trade bread recipes on a knead-to-know basis.

METRO NORTH HEALTH SERVICE DISTRICT
EXECUTIVE DIRECTOR, DIRECTOR MEDICAL SERVICES
REDCLIFFE HOSPITAL
Dr Donna O'Sullivan

Redcliffe Hospital has a unique place in the peninsula community and its surrounding suburbs.

Built in the 1960s after much campaigning by local residents, our hospital today is an outer urban health facility very much focused on serving the needs of the local community.

We are a secondary level hospital, which means we able to manage a wide range of issues locally. When we are unable to safely provide the level of clinical care here, patients are transferred to another - usually tertiary – hospital to ensure their health needs are met.

Redcliffe is a very busy hospital. Last financial year there were 52,919 presentations to the Emergency Department, 53,505 patients seen in the Specialist Outpatient Department, 1539 babies delivered, 4136 elective operations performed, 2409 emergency operations performed and 505 patients cared for in the Intensive Care Unit and 6591 medical patients admitted for care. Our committed hospital staff are focused on the care of our patients and the development of secondary level clinical services, ensuring that as many of our patients as possible can be provided with care in their local area.

We recognise the challenges of daily striving for the best outcomes for our patients and we may not always achieve the levels of care required. When this occurs we are very keen to know about it and greatly appreciate the time and effort our patients take to provide us with feedback. We are also keen to have feedback from the local medical community and to increase the communication channels between the hospital and that community. Hence my delight in being asked to provide regular commentary in this newsletter.

For those who may have not know me, I am a local University of Queensland graduate (1980) having grown up in Bundaberg. As a Queensland Health Scholarship holder I completed my country service in Gladstone after an internship at Royal Brisbane Hospital (RBH). Deciding to pursue Medical Administration as my clinical specialty, I returned to RBH (as it then was) for training which was completed at The Prince Charles Hospital with Dr Kevin Kennedy. After 10 years at Charlies (and 3 children) I took up the position of Director of Medical Services at St Andrew's War Memorial Hospital in Spring Hill where I remained for four and half years.

Then Redcliffe and Caboolture called. Since 1999 I have worked in this area, including four interesting and fruitful years at Caboolture. My role for all of this time has been as Director of Medical Services, a role which holds responsibility for the overall management of the medical staff in addition to contribution to the general executive management team.

During the recent restructure of Queensland Health and the creation of the Metro North Health Service District, I undertook the role of Executive Director Redcliffe Hospital in addition to my Director of Medical Services role. Outside of my hospital duties, I am an active member of the local branch of the Royal Australian College of Medical Administration and have recently taken on a national role in the education arena for the College.

One of my other involvements is with the Australian Council of Health Care Services. As a surveyor with ACHS I regularly travel to various parts of Australia surveying hospitals. My preference is always to undertake surveys in hospitals from which I can observe and learn about issues pertinent to Redcliffe and our services. I have also recently begun to survey internationally, in Hong Kong. In fact I am writing this piece in a transit lounge in Singapore en route to Hong Kong. Spending time in other facilities, speaking with clinicians and patients and collaborating with other surveyors, remains one of the best continuing education activities in which I am involved.

I look forward to sharing some of these experiences with you in the future.

Best Wishes: Donna
donna_osullivan@health.qld.gov.au

A Sentimental Story

Teddy & The Teacher

As she stood in front of her 5th grade class on the very first day of school, she told the children an untruth. Like most teachers, she looked at her students and said that she loved them all the same. However, that was impossible, because there in the front row, slumped in his seat, was a little boy named Teddy Stoddard.

Mrs. Thompson had watched Teddy the year before and noticed that he did not play well with the other children, that his clothes were messy and that he constantly needed a bath. In addition, Teddy could be unpleasant. It got to the point where Mrs. Thompson would actually take delight in marking his papers with a broad red pen, making bold X's and then putting a big 'F' at the top of his papers.

At the school where Mrs. Thompson taught, she was required to review each child's past records and she put Teddy's off until last. However, when she reviewed his file, she was in for a surprise.

Teddy's first grade teacher wrote, 'Teddy is a bright child with a ready laugh. He does his work neatly and has good manners... he is a joy to be around.' His second grade teacher wrote, 'Teddy is an excellent student, well liked by his classmates, but he is troubled because his mother has a terminal illness and life at home must be a struggle.'

His third grade teacher wrote, 'His mother's death has been hard on him. He tries to do his best, but his father doesn't show much interest, and his home life will soon affect him if some steps aren't taken.' Teddy's fourth grade teacher wrote, 'Teddy is withdrawn and doesn't show much interest in school. He doesn't have many friends and he sometimes sleeps in class.'

By now, Mrs. Thompson realized the problem and she was ashamed of herself. She felt even worse when her students brought her Christmas presents, wrapped in beautiful ribbons and bright paper, except for Teddy's. His present was clumsily wrapped in the heavy, brown paper that he got from a grocery bag.

Mrs. Thompson took pains to open it in the middle of the other presents. Some of the children started to laugh when she found a rhinestone bracelet with some of the stones missing, and a bottle that was one-quarter full of perfume. But she stifled the children's laughter when she exclaimed how pretty the bracelet was, putting it on, and dabbing some of the perfume on her wrist. Teddy Stoddard stayed after school that day just long enough to say, 'Mrs. Thompson, today you smelled just like my Mom used to.'

After the children left, she cried for at least an hour. On that very day, she quit teaching reading, writing and arithmetic. Instead, she began to teach children. Mrs. Thompson paid particular attention to Teddy. As she worked with him, his mind seemed to come alive. The more she encouraged him, the faster he responded. By the end of the year, Teddy had become one of the smartest children in the class and, despite her lie that she would love all the children the same, Teddy became one of her 'teacher's pets.'

A year later, she found a note under her door, from Teddy, telling her that she was the best teacher he ever had in his whole life. Six years went by before she got another note from Teddy. He then wrote that he had finished high school, third in his class, and she was still the best teacher he ever had in life.

Four years after that, she got another letter, saying that while things had been tough at times, he'd stayed in school, had stuck with it, and would soon graduate from college with the highest of honours. He assured Mrs. Thompson that she was still the best and favorite teacher he had ever had in his whole life. Then four more years passed and yet another letter came. This time he explained that after he got his bachelor's degree, he decided to go a little further. The letter explained that she was still the best and favorite teacher he ever had. But now his name was a little longer.... The letter was signed, Theodore F. Stoddard, MD.

The story does not end there. You see, there was yet another letter that spring. Teddy said he had met this girl and was going to be married. He explained that his father had died a couple of years ago and he was wondering if Mrs. Thompson might agree to sit at the wedding in the place that was usually reserved for the mother of the groom. Of course, Mrs. Thompson did. And guess what? She wore that bracelet, the one with several rhinestones missing. Moreover, she made sure she was wearing the perfume that Teddy remembered his mother wearing on their last Christmas together.

They hugged each other, and Dr. Stoddard whispered in Mrs. Thompson's ear, 'Thank you Mrs. Thompson for believing in me. Thank you so much for making me feel important and showing me that I could make a difference.'

Mrs. Thompson, with tears in her eyes, whispered back. She said, 'Teddy, you have it all wrong. You were the one who taught me that I could make a difference. I didn't know how to teach until I met you.'

(For you that don't know, Teddy Stoddard is the Dr. at Iowa Methodist in Des Moines that has the Stoddard Cancer Wing.)

Australian Medical Association Limited

42 Macquarie Street, Barton ACT 2600:
PO Box 6090, Kingston ACT 2604

ABN 37 008 426 793

T: (02) 6270 5400 F (02) 6270 5499
Website : http://www.ama.com.au/

PRACTICAL STEPS TO IMPROVE INDIGENOUS HEALTH

AMA President, Dr Andrew Pesce, said today that all parties and Independents in the new Parliament have a unique opportunity to work together to make real improvements in health outcomes and living conditions for Indigenous Australians.

Dr Pesce – accompanied by AMA Vice President, Dr Steve Hambleton, and AMA NT President, Dr Paul Bauert – has been in the Northern Territory this week meeting with health service providers and non-government organisations (NGOs) and visiting communities to experience first hand the delivery of health services to Indigenous Australians at the local level through successful models of care.

Dr Pesce said that these local successes and local ideas will need to be examined closely to judge whether they are appropriate to be implemented in other settings around the country.

"Improving Indigenous health must be a priority for the new Government and the new Parliament," Dr Pesce said.

"The health of Indigenous Australians must not be a political football. There must be unity of purpose to build on the positive messages of support for Aboriginal people and Torres Strait Islanders from our political leaders in recent weeks.

"There is a health reform process currently underway and we must use it to improve the health and living conditions of Indigenous Australians, and not just those who live in the remote communities of the Territory and northern Australia.

"First, we must ensure that the transfer of 100 per cent of primary health care funding to the Commonwealth does not disadvantage Aboriginal Health Care services at the local level.

"The Commonwealth must fully replace any funding from other sources that may be lost through the transition of control from the States and Territories.

"In the Northern Territory, for instance, some Aboriginal Health Care services operate under a pooled funding model that combines some State funds with Commonwealth funds.

"The Aboriginal Health Care Worker workforce must be properly supported, including a commitment for at least some of their training to be at the community level.

"Training at the community level is vital to sustainable local recruitment and retention of Aboriginal health workers and other community based workers.

"The new Government must engage seriously with the community controlled concept of health service delivery to incorporate evaluation of program development to make sure there is ongoing improvement in services.

"Importantly, we need a coordinated approach to capacity building in relation to the social determinants of health.

"The AMA is encouraged by the NGOs, including the Aboriginal Community Controlled Health services, we have met in the Territory this week.

"They have a commitment to improve living conditions up here – including housing, education, sanitation and water - and we must ensure that their efforts are well coordinated and that they can work in partnerships.

"There must be a strong national effort to improve nutrition, improve education, improve housing, and improve employment opportunities through real training, real jobs and real support.

"All these things impact on people's health.

"The AMA wants a Centre of Excellence in Indigenous Health Workforce Training established, and a professional development unit focused on remote Indigenous Health Service delivery.

"This would provide opportunities for both Aboriginal workforce career path development and the incorporation of Indigenous health training into the general postgraduate medical curriculum.

"It would complement the existing Centre of Excellence at Inala in Queensland, and could form part of a national network of Centres of Excellence in Indigenous health care.

"There is a lot of work to do in Indigenous health. The AMA will be working hard to maintain Indigenous health as a policy priority for all politicians over the life of the current Parliament,"
Dr Pesce said.

9 September 2010

CONTACT:

John Flannery 02 6270 5477 / 0419 494 76
Geraldine Kurukchi 02 6270 5467 / 0427 209 75

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION.

The objects for which the Association is established are:

(1) THE PROMOTION OF THE MEDICAL EDUCATION OF THE MEMBERS, AND OF THE LOCAL COMMUNITY.
(2) PROMOTION OF THE MEDICO-POLITICAL INTERESTS OF THE MEMBERS, PATIENTS, AND THE LOCAL COMMUNITY.
(3) LIAISON WITH OTHER MEDICAL REPRESENTATIVE BODIES.
(4) THE PROMOTION OF QUALITY MEDICAL SERVICES.
(5) PROMOTION OF AN ENVIRONMENT TO FACILITATE AND ENCOURAGE SOCIAL INTERACTION BETWEEN ASSOCIATION MEMBERS.

We are here to

(1) TEACH AND LEARN
(2) BE INFORMED ON MEDICAL POLITICAL ISSUES AT ALL LEVELS
(3) LOBBY ON LOCAL POLITICAL ISSUES
(4) WORK WITH OTHER DOCTORS' GROUPS
(5) WORK FOR THE BENEFIT OF OUR PATIENTS
(6) NETWORK AND HAVE A GOOD TIME TOGETHER.

MEMBERSHIP APPLICATION AND RENEWAL FORM

MEMBERSHIP SUBSCRIPTION FOR THE PERIOD: 1ST JULY 2010 TO 30TH JUNE 2011

The Redcliffe and District Medical Association Inc. invites you to join our Association.

YOUR MEMBERSHIP GETS YOU

- FREE ENTRY TO OUR MONTHLY MEETINGS (10 MEETINGS A YEAR)
- MONTHLY NEWSLETTER (AT LEAST 10 ISSUES A YEAR)
- FREE ENTRY TO OUR END-OF-YEAR NETWORKING MEETING.
- THE ONLY LOCAL CONVOCATION FOR GENERAL PRACTITIONERS AND SPECIALISTS TO SOCIALIZE AND TO DISCUSS LOCAL AND NATIONAL MEDICO-POLITICAL ISSUES.

Subscription rates:

Full Annual Rate	$100.00
Doctor Spouses Full Annual Rate	$ 75.00 each
Half Year from now until 30/06/2011	$ 80.00
Doctor Spouses half-year from now until 30/06/2011	$ 55 each
Students and Doctors-In-Training	Free
Retired Doctors	Free

NOTE THAT AMA MEMBERSHIP DOES NOT GRANT YOU RDMA MEMBERSHIP.

WE PREFER PAYMENT OF YOUR SUBSCRIPTIONS BY INTERNET BANKING. IT SAVES YOU WRITING CHEQUES AND SAVES US HAVING TO BANK THEM. YOU WILL RECEIVE YOUR RECEIPT BY EMAIL IF YOU SUPPLY YOUR EMAIL ADDRESS TO THE TREASURER ON GJS2@NARANGBA-MEDICAL.COM.AU.

REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc

ABN 88 637 858 491

I hereby apply for membership of the Redcliffe and District Local Medical Association, and agree to abide by the Rules of the Association.

Signed:	
Doctor:	
(First Name)	(Surname)
Email Address:	
Practice Address	**Postcode**
Phone	**Fax**

Membership fee enclosed, or

PREFERABLY Paid by: Internet Banking (Remember to place your name on the deposit i.e: Dr. F. Bloggs RDMA) **Account: BSB 064 122 Account: No: 0090 2422 Redcliffe & District Medical Association/ Date and Bank Paid**

Please complete this form and return to: Redcliffe & District Medical Association Inc. P O Box 223 Redcliffe 4020 OR c/-QML or by email to GJS2@Narangba-Medical.com.au

Our Demographic Home
Humpybong