RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
DECEMBER 2016

RDMA's Christmas Party Celebration at the Golden Ox Page 20

See Where We Work & Live on page 20.
RDMA's Christmas Celebration

President's Report Dr Kimberley Bondeson

Merry Christmas to everyone, and a Happy New Year! The end of year Christmas function was well attended and thoroughly enjoyable. I also had the pleasure of attending the North Side LMA Christmas function, which was a great evening as well!

It is hard to believe that the year is nearly over. And what a year it has been! An election, promises to look at Medicare, which has not happened, (and are unlikely to happen under the present government). The number of medical graduates is increasing, and there are ongoing problems with the number of training places and intern training places.

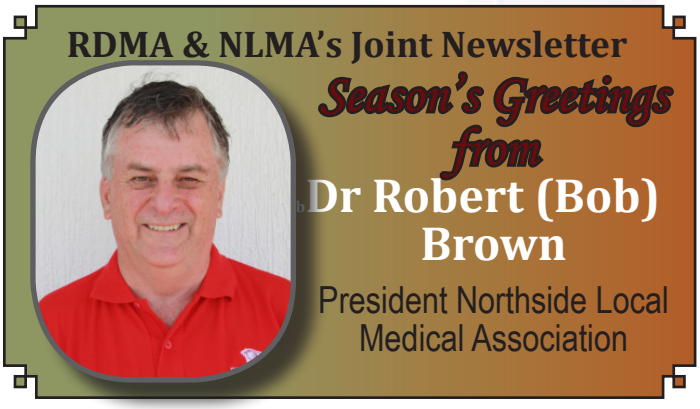
It would seem that the latest medical workforce prediction has stated that there should not be any more medical schools in Australia, due to the large number of medical graduates being produced. Australia is now the leading developed country producing the most medical graduates per head than any other developed country. Quite a position to be in, and will very much change the way that medicine in the future in Australia is practiced. It is already putting tremendous strain on training positions and intern placements. And not in a positive way. All specialities across the board are affected.

Now onto MyHealth Records; of interest, The Australian Digital health Agency (ADHA) warns on its website that "it is safest to assume" a MyHealth Record is incomplete unless the patient confirms the information. "'in other words, the information stored on the MyHealth Record system should not be used in an emergency or any other circumstances where patients are incapable of providing their clinical history". "The very agency responsible for the clinical usability of the system – the Australian Digital Health Agency – is advising signed up or linked treating clinicians and healthcare providers not to rely on it".

They also state that the system does not cover most private hospital or private specialists and are questioning what the purpose of it is. If the patient controlled eHealth record has pages deleted from it by patients, and that clinicians can't tell if this has been done, added, or deleted information, then what is the purpose of this electronic health records legislation?

A good question!. So who would benefit from this type of record? We will just have to wait and see what unfolds. There is still nothing better than a good history and clinical examination of a patient.

Seasons' Greetings to everyone, and a Very Happy New Year!.
Kimberley Bondeson,



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RDMA 2017 MEETING DATES:

For all queries contact Kristina Craner or Anna Wozniak Meeting Conveners: Phone: (07) 3049 4444

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Wednesday	February	22th
Tuesday	March	28th
Wednesday	April	26th
Wednesday	May	24th
Tuesday	June	27th
Tuesday	July	25th
ANNUAL GENERAL MEETING - AGM		
Wednesday	August	23th
Tuesday	September	12th
Wednesday	October	25th
NETWORKING MEETING		
Friday	December	1st

RDMA NEWSLETTER DEADLINE

Advertising & Contribution 15 FEBRUARY 2017
Email: RDMANews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

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W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants

Time: 6.45 pm for 7.15 pm

1	February	14th
2	April	11th
3	June	13th
ANNUAL GENERAL MEETING - AGM		
4	August	8th
5	October	10th
6	December	12th

Next Meeting Date 22nd February 2017

02.12.16 Dr Kimberley Bondeson, RDMA President introduced Mrs Margaret McPherson and thanked her for her excellend and ongoing contribution to RDMA and LMA members as the RDMA Meetings Coordinator and selfless devotion to the memberhip. RDMA's Executive thanked and farewelled Margaret MacPherson wishing her all the best in her new QML Position. Margaret also handed over to her new Co-Meeting Coordinator and sucessor Ms Anna Wozniak

Clockwise: 1. RDMA Farewelled Margaret MacPherson with a gift and gratitude. 2. Drs Kimberley Bondeson and Wayne Herdy. 3. Kimberley presenting Margaret her farewell gift. 4. Margaret and Ann 5. Ann and Paul Angel. 6. Karen Flegg and Peta McLaren 7. Geoff Talbot, Bob Brown and Zelle Hodge.

INSIDE THIS ISSUE:

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Health Care Homes, MBS Changes and Proposed Revalidation Scheme.

The National Disability Scheme is being rolled out – and according to several of my patients, is a headache.

They are already severally disabled, in care, and permanently wheelchair bound, but still have to apply individually to the new scheme, to have continuing care.

One of the difficulties with this is providing all the documentation and '"evidence" of their disability. Records are required from birth, which require specialist diagnosis and forth.

I can see why the population group that will be disadvantaged in this process will be those with mental health problems, who are disorganised, and are transient in their addresses. Will they be able to access and organise those records, and submit them? Or will they simply fall off the radar, and slip into more disorganisation and disarray?

Revalidation is another big topic – in some form or another, a change is on the way. How this unfolds and affects the medical profession is being debated.

Whether any changes introduced will make any difference to our patients is also being discussed. Is there any evidence that imposing revalidation on doctors makes any difference to patient care and outcomes? So far, the evidence is not there.

The current proposals of 'selecting out vulnerable doctors' seems to be bias towards male, isolated and older doctors. Personally, I have always thought this group to be some of the most knowledgeable, most experienced group.

Selecting this group out seems to be based on the fact that this group attracts the largest number of complaints.

They would also appear to be the group who are longest in practice.

So to my mind, it is simply that the longer one practices, the more likely there is to be dis-satisfied patients, who in this legal environment, are more keen to seek legal advice, then to accept that their conditions are often, and tragically, not treatable and not avoidable.

The question of legalising euthanasia is also a big one – and is been driven by the people (society) themselves.

It is interesting to see how this evolves and unfolds.

We look forward to 2017!.

Sincerely Kimberley Bondeson

New RDMA Co-Meeting Convener

Ms Anna Wozniak,

CONTACT DETAILS:
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AUSTRALIAN MEDICAL ASSOC PRESIDENT
DR CHRIS ZAPPALA

MEMBERS' UPDATE

Dear Members,

As all would be aware there has been controversy (once again) regarding pathology collection centre rents for space in general practices. This issue has the potential to divide us and create enervating disproportionate animosity. It is therefore very important that we begin by recognising what we agree on – which is actually most things. Please read the recent AusMed article on this topic and note the Federal AMA President's comments.

I understand that general practice is becoming an increasingly marginal enterprise as profits continually get squeezed – by the combination of greater practice costs and administration with frozen rebates and a hostile funding environment. I was aghast, however, to hear that some practices apparently survive on their 3rd party rent alone! It's a very sad day indeed when general practitioners are only just paying the bills in trying to offer good care to their patients and service a community. If you are in or close to this appalling situation, then please contact the AMA to obtain assistance in transitioning to a blended billing model for your practice. We can help shift you away from bulk-billing if desired. When we reflect on this circumstance in general practice, it perhaps more slowly dawns that pathology is in exactly the same position. Stand-alone full service laboratories now only exist in large conglomerates with significant economies of scale and often vast diversification of activity in other areas and/or overseas.

The real culprit here is the slavery of bulk-billing. The Government (and both sides of politics) know that the MBS rebate freeze is causing hardship across medicine. National health care spending trends clearly show a reduction in Commonwealth expenditure with a significant increase in payments by patients. This is the plan, shift to a user pays system by stealth and allow the doctors to appear a squabbling, avaricious ruckus.

The AMA across the country opposes the MBS rebate freeze – not because we want to preserve bulk-billing, as erroneously presumed by some, but because of the perversions emerging in the health care system, such as the difficulty surrounding pathology collection centre rents in general practice. In addition, obviously, the opposition to the MBS rebate freeze is aimed to make it easier for doctors to charge what they are worth, take time to see patients, be properly remunerated and to promote high-quality medicine that necessarily takes a little longer. Bulk-billing is not good for patients, not good for doctors – it is only good for politicians.

Doctors are entirely reliant on an efficient, superlative pathology system. Unfortunately, patients expect to be bulk-billed for this at greater rates than they even do in general practice. General practice is the foundation of our health care system and already very efficient. The profession and our patients needs both sectors to be resilient. I am aware of no evidence that suggests inappropriate referrals occur from landlord doctors to pathology companies. The suggestion that this is the case is offensive and needs to be struck down immediately. Our profession should be able to easily confirm compliance with the prohibited practice laws – so let's not overstate this as an issue at all.

If it is true that disproportionate financial arrangements exist between general practitioners and pathologists, I'm sure collegiate discussion can lead to a positive method to identify such situations and develop a strategy to transition back to arms-length, fair and transparent arrangements. This is where the AMA is crucial to facilitate discussion amongst the profession and assist in producing an outcome that protects all doctors (remember, no matter what we do, we depend on general practitioners and pathologists) and hopefully produce an optimal outcome for all parties. Rather than taking exception at single comments that the AMA might make through the process, it is my hope that doctors realise our best chance in such disputes is to manage them within the AMA, together. When other interest groups negotiate independently with Government it is rarely helpful. How often have Governments used division within medical ranks to discredit us and weaken our bargaining position. It's one of their favoured tactics.

Continued on Page 7

Dr Chris Zappala Australian Medical Association Qld President

cont from page 6

Thankfully, the Federal AMA has undertaken to get all parties talking together again and helped facilitate discussion with the Commonwealth. No further Commonwealth action will be taken until an agreed, equitable outcome that disadvantages no one, has been achieved. I do think this can happen – but, as always, it is done with positive, collegiate discussion through the AMA and not from silo groups or entrenched parochial perspectives. Only our professional association that represents all doctors can do this and those who give up on our collegiate and collective worth by resigning from the AMA or even worse, criticising, merely diminish our stature and advocacy potency as doctors. The AMA brings us together and finds common ground among us all – just what is needed to solve this problem.
Sincerely,

Dr Chris Zappala
AMA Queensland President

2017 Date Claimers

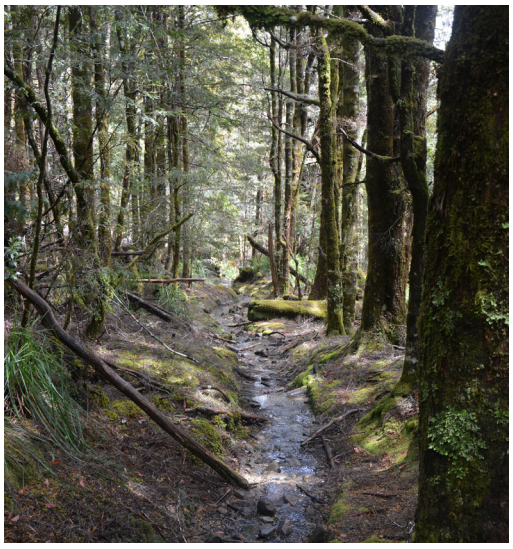
RDMA 2017 MEETING DATES

Wednesday February 22nd
Tuesday March 28th
Wednesday April 26th
Wednesday May 24th
Tuesday June 27th
Tuesday July 25th
AGM Wednesday August 23rd
Tuesday September 12th
Wednesday October 25
Networking Function
Friday December 1st

OVERLAND TREK, Dr Wayne Herdy,

If you open any website proclaiming the best ten long-distance treks in the world, you can practically guarantee that Tasmania's Overland Track will rate a mention.

Every year, more than 8,000 hikers traverse the 6-day 65-km walk from Cradle Mountain to Lake St Clair. Most add at least a few of the side-trips which can add another 30-odd km to the walk. Only 40 hikers are allowed to start the Track each day during the peak season (from 1st October to 31st May, you can only walk the Track from North to South). Traditionally the Track is walked in set stages, from one overnight hut to the next. The smallest huts only sleep 16 on the designated wooden platforms (that's right, no bunks), so many walkers sleep on the floor or outdoors in tents.



In December this year, I walked the Overland a second time. I don't usually visit treks a second time, but when I walked the Track 2 years ago the weather was so lousy that I got few photographs. I also had company this year, my daughter and her partner.

A lot of the Overland Track boasts boardwalks, but don't be deceived. There are enough natural surfaces, including tree roots and shin-deep mud or rocky rivulets, to make the going arduous. As a walk in the national park goes, this is no "walk in the park". 10 km a day doesn't sound a lot, until you wind up and down hills and through creeks and close scrub, carrying a load that might start at over 20kg (plus about 3kg of camera if you own a couple of Nikons).

The low point for every Overland walker is the second hour of day one. At a time when your muscles are not yet tuned in, and your pack is at its heaviest, there is a 60-degree scramble up a rocky incline pulling yourself along a chain rope. After that, the rest is (relatively) easy.

The highlight of this year's expedition was a delightful surprise on day 3, when we woke to about 4cm of snow (Australia in December!). It was enough to make some pretty pictures but not enough to make it dangerous or, rather, more dangerous.

Overland trekking is not a trivial pursuit. The Overland saw two deaths this year from hypothermia – in summer. If you get into real trouble, the only way out other than walking is by helicopter, which can only find you if somebody is carrying a Personal Locator Beacon.

No overland trek is undertaken without

OVERLAND TREK, BY DR WAYNE HERDY CONTINUED:

foreknowledge and preparation. Anybody planning a distance trek for the first time has to plan – if you want to not only survive the walk but even enjoy it, you cannot have too much information. You have to carry the right gear, including your food for the entire trip and enough water to last to the next known water point. And the planning always boils down to a balance between your fitness and your payload in a hostile and potentially lethal environment. Fitness and training are essential, because when you get out into the boondocks, you are the one who has to carry every gram of kit on your back.

The websites and guidebooks are pretty good, but you cannot beat the first-hand knowledge of somebody who has done it. And the one piece of kit that you cannot skimp on is a first-class pair of boots, well-worn in long before you start. Everything else is a footnote.

But for those prepared to put in the preparation and the effort, the reward is priceless. At the most superficial level, you get to live in some of the most spectacular and unspoiled natural scenery that Australia has to offer. Less superficially, you get to meet dozens of like-minded souls from all around the world, sometimes for fleeting friendships and sometimes for long-lasting relationships, but always with shared and diverse experiences of what life in the modern world is all about. And, to my mind at least, the most profound experience is the opportunity to reflect on the real meaning of life. As one of the signs on the Track says (paraphrased): “You don’t come out here to get away from it all, you come here to get back to it all”.

It is a reality that pitting yourself against nature with only your own resources brings each individual back to the basics of who and what they really are.

Wayne Herdy

LETTERS TO THE EDITOR

8 December 2016

RDMA Newsletter

Dear Editor

Recently I wrote the following letter dated 8/11/2016 (attached) to the president of the RACGP regarding mandatory requirements for GPs in their new CPD triennium beginning in the New Year 2017.

As yet I have not received any reply from him. All doctors should read my letter and ignore this requirement.

They should write to the College to support my stance if they wish to be mentally healthy, independent and free individuals in their own right.

Yours sincerely

Mal Mohanlal
8 November 2016

Dr Bastian Seidel
President
RACGP House
100 Wellington Parade
EAST MELBOURNE VIS 3002

Dear Dr Seidel

Congratulations for being elected as the President of the RACGP. You have indeed an unenviable task ahead.

Mental illness is increasing in every society of the world today. This is because our perceptions are constantly being distorted by the media, the politicians and the consumer world around us. If we as doctors behave in the same way as the rest of society, we ourselves become part of the problem.

As you can see that there are increasing numbers of doctors committing suicides. It means that doctors themselves have no insight into their own mental health. Yet these are the same doctors giving advice to their patients who are suffering from stress, anxiety and depression etc. Is it not the blind leading the blind?

Our education system is regulatory and coercive from primary to secondary and to the tertiary levels. It means that the individual is being conditioned negatively or positively by our system at all these levels. This where the culture of bullying and coercion is learned and experienced by our students. After tertiary levels surely the individual should be allowed to think for himself and develop his own skills, seek and gain knowledge from life and professional experiences without coercion of any kind.

However it seems that the RACGP and other colleges still believe in treating professionals at the post graduate level in the same regulatory way as when they were young students. There is now a general consensus that bullying is a mental health issue. In my mind the government is the greatest bully in our society because it uses coercive methods to achieve what they want. By co-operating with the government in these methods, it is clear that the colleges are also supporting this culture of bullying and competition at the post graduate level. Surely the medical profession should recognise this problem and deal with it in a different way.

Please let me get this straight. We are unlike any other profession. We are unique because we are the guardians of not only **Continued Page 11**

the physical but also the mental health of the individual. We cannot be classified in the same category as the other professions because if we behaved like other professions we would not be able to correct them on any mental health issues.

To use coercive measures in post graduate education as is happening at present is surely a regressive step. It merely invites all the clever minds to use their brains to manipulate and exploit the system to satisfy the government requirements. It does not mean that we are practising any higher standard of medicine. It would be a delusion to think otherwise.

I would kindly request the RACGP to reconsider any mandatory CPD requirements in the new triennium and abandon its coercive approach. Learning cannot be coerced. One can take a horse to water, but one cannot force it to drink. The medical profession stands for compassion and consideration for others. Has the college any duty of care towards their own members' mental health or will they continue to play the role of Porky Pig selling pork chops and pork sausages on behalf of the government?

Unless a responsible organisation likes yours takes a different approach to post graduate education, I see little hope for doctors improving their own mental health or for society to improve its mental health. As doctors we are not here merely to diagnose disease and prescribe medications. We are also here to help people change their perceptions so that they can help themselves. We cannot do this without insight into our own minds.

Please find enclosed a complimentary copy of my book "The Enchanted Time Traveller – A Book of Self-Knowledge and the Subconscious Mind" and some recent literature which is relevant to what I have just written. All health professionals should be reading it to try to understand their own mind. It helps my patients to understand themselves better.

With kind regards and best wishes

Yours sincerely
MAL MOHANLAL

MONTSERRAT
— CANCER CARE —

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

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

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

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

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

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

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

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

Kind Regards

Montserrat Cancer Care Team

**The Orbis Cooling machine*

MONTSERRAT
— CANCER CARE —

Excellence in Cancer Care Across South East Queensland

Our clinics are built with patient outcomes, comfort and atmosphere in mind. Our Day Spa environment makes people feel welcome, calm and nurtured. The manner in which we care for them eases the experience and provides a high level of dignity and excellence that all people deserve.

Providing treatment for blood disorders and cancer:

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- Iron Infusions
- Bisphosphonate Infusions
- Supportive intravenous therapy
- Blood Transfusions
- Blood product support
- Patient education and support
- Supportive Allied health services Dietician, Exercise and Massage

Meet Our Team

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

Dr Hong Shue
Medical Oncologist
***SC**

Dr Sorab Shavaksha
Clinical Haematologist
***SC**

Jesse Goldfinch
Excercise Physiologist
***SC**

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

Dr Peter Davidson
Consultant Haematologist
***NL**

Dr Kieron Bigby
Medical Oncologist
***NL**

Sarah Higgins
Dietician/ Nutritionist
***SC**

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

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

Tania Shaw
Oncology Massage Therapist
***SC**

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

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

Be Our Guest

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

North Lakes Haematology & Oncology Clinic
Tel: (07) 3833 6755 | www.nlhoc.com.au
7 Endeavour Bvd, North Lakes Q 4509 (next to OzCare)

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

The Medical Journal of Australia • MJA
MEDIA RELEASE

SEXUAL TRANSMISSION OF HIV AND THE LAW: CAUTION ADVISED

THE criminal justice system should exercise caution in prosecuting for the transmission of HIV by considering the rapidly evolving science of the virus, say a number of leading clinicians and scientists in a consensus statement published today in the *Medical Journal of Australia*.

There have been at least 38 Australian criminal prosecutions for HIV sexual transmission or exposure since the first known case in 1991. Such cases require courts, legal practitioners and juries to interpret detailed scientific evidence on HIV transmission risk and the medical impact of an HIV diagnosis. In some cases, according to the authors, the risks and impacts of HIV infection may have been overstated.

Professor Mark Boyd and colleagues wrote that future criminal allegations needed to be addressed in a robust way that considered the best available medical and scientific evidence.

Current evidence demonstrates that, unlike the risk of transmission through HIV-infected blood, which rises to almost 100% through blood transfusion, the risk of transmission through sexual encounters between partners of different serostatus can be low, negligible or too low to quantify. This can depend on the nature of the sexual act, the viral load of the partner with HIV, and whether a condom or pre-exposure prophylaxis is used to reduce the risk.

Additionally, the advancements of HIV antiretroviral drug regimens over the past two decades have made treatment more simple, tolerable and effective. This improved treatment for people infected with HIV has meant that their life expectancy is comparable to that of their HIV-negative peers.

The authors wrote that in the rare clinical instances when a person was dismissive of the need to protect others from their HIV infection, public health management could be an effective alternative to prosecution.

“Public health management guidelines in each state and territory focus on achieving sustained behaviour change through counselling, education and addressing the underlying causes of risk behaviour,” the authors wrote.

Where such recourse was not appropriate, the authors recommended that prosecutorial authorities refer to current scientific evidence.

“HIV science continues to deliver impressive results,” the authors wrote. “Given the rapid pace at which science is evolving, reference to risk and harms associated with HIV must reference the most robust and up-to-date evidence.”

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The Medical Journal of Australia • MJA
MEDIA RELEASE

TRAUMA MORTALITY DECLINES IN REGIONAL AND REMOTE NSW

INPATIENT mortality associated with major trauma has declined in rural and remote NSW following changes to the state trauma management system, according to research published today in the *Medical Journal of Australia*.

The study led by Associate Professor Michael Dinh from Royal Prince Alfred Hospital and The George Institute for Global Health, and Professor Kate Curtis, from the University of Sydney, and colleagues analysed NSW trauma registry data to determine crude and risk-adjusted major trauma mortality rates in rural and metropolitan NSW between 2009 and 2014. The patients included in the research were aged 16 years or more and had been hospitalised with major trauma.

The registry, established and maintained by the NSW Institute of Trauma and Injury Management, receives data from seven major trauma centres and ten regional trauma centres, including the Abbreviated Injury Scale (AIS) score, which codes injuries and their severity according to their anatomic location and likelihood to cause disability or death.

11 423 patients were identified in the registry who met the inclusion criteria, 77% of whom were injured in metropolitan areas. The average age of the patients was 53.5 years; 71.9% were men, who were mostly injured in falls and road accidents.

The revised NSW State Trauma Plan, implemented in 2009, formalised rural and regional referral networks for each of the seven adult major trauma centres. The aim of these networks was to facilitate the timely transfer of severely injured patients from sparsely populated rural and remote areas of NSW to major trauma centres in metropolitan areas along the east coast.

The researchers found that the crude mortality rate had most markedly declined since the introduction of the revised plan among patients severely injured in outer regional and remote locations in NSW. There was also a reduction in risk-adjusted mortality associated with rural location of injury.

The authors suggest that the decrease could be explained by the establishment of trauma referral networks, which has resulted in more efficient transfers between rural facilities and major trauma centres. Improved clinical care in regional trauma centres and rural referral centres may also have contributed to the decline. A core mission of the NSW Institute for Trauma and Injury Management over the past decade has been to coordinate and improve access to clinical expertise and education resources in these centres.

The lack of overall improvement in major trauma mortality in metropolitan NSW, however, was highlighted by the research authors as a cause for concern.

[There is an] ongoing need for quality improvements in the major trauma system in NSW, including improved networking of trauma centres with rural and remote regions and models of care that sustainably manage the growing proportion of older major trauma patients, the authors urged.

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Northern Lights Cruise

Scandinavia

by Cheryl Ryan

The breath-taking view of the fjords and wondrous phenomena of nature like the Northern Lights and the Midnight Sun make a Scandinavian cruise an adventure that will stay in your heart forever. Iceland, Sweden, Finland, Norway and Greenland offer excellent opportunities to have an Aurora holiday. Set your camera ready on its tripod, lie back and watch in wonder as the mystical northern lights dance across the night sky.

The aurorae promise of the Arctic skies

The greatest pleasures of a Scandinavian cruise are the Arctic Circle's vast pristine blue waters, plenty of onshore fun activities, and the inexplicable joy of witnessing the dancing aurorae.

1. Bodo, Norway: Sitting between rugged mountain peaks and fjord islands, this industrial centre is bountiful in raw natural beauty and inspiring public art. Have a feel of Norway's Viking history, Sami people's indigenous culture, and fishing industry at the Nordlandmuseet museum exhibits. Norsk Luftfarts museum features aviation military exhibits.

2. Vesteralen and Lofoten Islands, Norway: Snoop into the past at the archaeological sites of Stone Age colonies as well as picturesque fishing villages like Stamsund. On Lofoten, visit Borg – a home-museum that brings to life Viking memorabilia.

3. Tromso, Norway: Discover Norway's polar past at Tromso's museums and architecture scene. Don't miss out on husky dog-sledding and snowmobiling and thereafter, hit a pub in this North Sea's 'party port'.

4. Alta, Norway: Home to the world's first northern lights observatory as well as copious ancient rock art, this UNESCO World Heritage site is a must-see.

5. Kirkenes, Norway: Rich in history and iron ore, the urban town is where you can encounter the unique lifestyle of Sami, snowmobile and savour frozen fjord-caught King Crab dinners.

6. Reykjavik, Iceland: Experience scintillating nightlife, soak in steamy geysers, visit the heritage site Thingvellir National Park and the marvellous two-tiered waterfall at Gullfoss – all in this exciting capital of Iceland.

What have we planned for you?

- A comprehensive itinerary has been developed to include all the splendid Scandinavian destinations
- Embark on a cruise in Bergen, Norway, which is atop a fjord and ringed by seven hills.
- Arrive at the third-longest fjord in the world – Hardangerfjorden, and explore the area on kayak, Zodiac and hiking trips
- Arrive on the coast of Flekkefjorden and hike on Hidra, the island rich in Viking history. Visit the Hagasan Fort. Resume sea cruise along the southern fjords of Norway.
- Cross the Arctic Circle and reach Norway's Lofoten Islands for sightseeing and kayaking.
- Explore Tromso, Norway with wildlife, sightseeing, history, culture, nightlife and shopping opportunities
- Dock at Vesteralen Islands for excursion
- Cruise across the Skagerrak strait to Weather Islands in Sweden for exploration and kayaking. Anchor at Grebbestad to visit the Bronze Age rock carvings in Tanum
- Arrive at Reykjavik in Iceland. Plenty of sightseeing and recreational adventure opportunities.
- A short extension of the journey shall be arranged if the northern lights don't come out during the cruise

www.123Travelconferences.com.au

WHAT'S YOUR PLAN?

Poole Group
ACCOUNTANTS & INVESTMENT ADVISERS

Last night I received a text from my Bank that my credit card had been fraudulently used, I was asked to reply Yes for me No for Fraud. I reluctantly responded No, with the thought in my mind that it couldn't possibly happen to me and this was just a scam. The text response I received back advised I would receive a call within 20 minutes. At 10pm a lady with poor English phoned me to discuss the incident, I promptly advised her that no bank would call at 10pm at night and that she was a hoax and then I hung up.

Well wasn't I wrong. Friday morning on the way to work I enter the local service station to fill up my car with fuel. As I stand at the cash register (wearing my Poole Group uniform) both of my cards are unceremoniously declined. Suffering severe embarrassment the next thought that enters my mind, is how am I going to pay for this? I rarely carry cash like every other person I know and rely heavily on my cards. In sheer desperation and as the sweat beads run down my face I call the bank. They feel my pain and lift the ban for 2 minutes to process my fuel purchase. Then I'm advised my cards are useless again. Being Friday sheer panic again overcomes me, how will I survive the weekend? Again the bank comes to my rescue and allows me to do a cardless withdrawal at the ATM.

So why am I writing this article? With events of this morning freshly etched in my mind and with Christmas approaching I thought it might be a good idea to challenge everyone to think of your backup plans, not just financial backup plans but life in general.

As experienced this morning what is your plan if this happens to you? It's a possibility over Christmas that it could. The transaction on my card was for a US business, the Bank flagged the payment as the business itself is real, but a high volume of fraudulent transactions have been charged to them recently.

Although this event in hindsight is minor it does serve as a reminder to have a contingency plan in place. There are so many events in life that can bring both your life and business to a screeching halt fire, flood, death, GFC, fraud, sickness, power blackouts, job loss, divorce.

I think we would all be smart to think about what we can do to minimise the impact of these events in our life. I thought I was quite organized and had a plan for all of the above events. I have completed my Will, supplied my executors copies, have a Will folder setup for them and discussed with them all of my financial and personal wishes. I have life insurance, superannuation, trauma, income protection, car, house, private health insurance. My cupboards at home are stocked with food & water that would keep me going for a week.

It's funny, in spite of all of my planning I couldn't pay a $60.80 fuel bill this morning. I'm not sure what the solution is other than to think and prompt you all to take the time to consider what you need to do for you, your family and your business and develop your own contingency plan.

And me, I figure I'm well covered, but when I get home tonight, my gold coins are going straight in my piggy bank tin.

From all of us at Poole Group, Happy holidays everyone. May you all have a fabulously Festive Christmas and a Happy New Year.

Written By Kerri Welsh (Manager) Poole Group 07 54379900.

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AMA

Equipping Doctors to provide vital and sensitive support to victims of family and domestic violence, AMA Position Statement 2016

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA President, Dr Michael Gannon, said today that doctors have a unique and trusted role to play in the early detection, intervention, and treatment of patients who have experienced family and domestic violence. Releasing the AMA's revised and updated Position Statement on Family and Domestic Violence 2016, Dr Gannon said the AMA is committed to providing important information and guidance to empower doctors, especially GPs, to provide better support for victims.

Ahead of the COAG National Summit on Reducing Violence against Women and their Children, which commences in Brisbane today, the AMA is calling on all Australian governments to properly fund and resource, on an ongoing basis, specialised family and domestic violence support services, including housing and crisis accommodation. Dr Gannon said it is disturbing and unacceptable that, in a modern and sophisticated nation like Australia, a large number of women experience some form of physical or sexual violence in their lifetimes. "Two women are killed nearly every week in Australia due to family and domestic violence," Dr Gannon said.

"The health effects of family and domestic violence in both the immediate victims and their families are devastating, and it is not only women who are the victims. "Family violence affects people of all genders, sexualities, ages, socio-economic backgrounds, and cultures. "And we are now also seeing increasing instances of elder abuse, with grandmothers and grandfathers, many frail and vulnerable, being subjected to violence from family members. "Men can be victims. Women can be perpetrators. But it is clear that the overwhelming majority of people who experience such violence are women. "The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal ideation, and substance abuse. "There are also serious physical health effects including injury, somatic disorders, chronic disorders and chronic pain, gastro-intestinal disorders, gynaecological problems, and increased risk of sexually transmitted infections.

"As a community, we must stamp out violence against Australian women, and bring an end to all forms of family and domestic violence, whoever the victim. "This will involve commitment and coordination from governments; support services; the related professions, especially medical, health, and legal; neighbourhoods; and families – backed by adequate funding." Dr Gannon said that health care providers may see more results of violence in their patient contacts than law enforcement agencies.

"Women experiencing domestic violence will share their experiences with GPs more often than with any other professional group," Dr Gannon said. "The health impacts of family and domestic violence persist long after the violence ceases. "Women who have experienced this violence report higher levels of mental disorders, increased rates of physical disorders, impaired quality of life, and higher rates of suicide attempts. "Children who grow up witnessing and experiencing domestic violence can also be profoundly affected."

Dr Gannon said that education, awareness, interventions, and models of care that help both victims and perpetrators are desperately needed. "All doctors need access to training that exposes the extent of different forms of family and domestic violence, and the medical and psychiatric consequences for the victims – be they men, women, children, young, or old. "Special care is also needed for the perpetrators. "Responding effectively to family violence requires knowledge of the physical and emotional consequences of the violence, an understanding of appropriate and inappropriate responses, and having good networks with local family and domestic violence services. "Family and domestic violence is a national crisis that needs a national solution, with a local focus and local responses," Dr Gannon said.

Background

- In 2014, Police recorded 95 victims of family and domestic violence-related homicide offences
- 40 per cent of women received injuries
- Intimate partner violence is the leading contributor
- One in six women have experienced physical or sexual violence from a current or former partner; one in three women have experienced physical and/or sexual violence by a known perpetrator.
- The Australian Bureau of Statistics' Personal Safety Survey estimated that 5.3 per cent of men and 16.9 per cent of women have experienced physical or sexual violence perpetrated by a current or previous partner since the age of 15.
- The ABS survey estimated that 14 per cent of men and 25 per cent of women have experienced emotional abuse by a partner since the age of 15.
- A woman is ikely killed at home by male partner
- 62 per cent of women and 8 per cent of men experienced physical assault in their home.
- It is most common for women to experience violence from a male ex-partner.
- Perpetrators of family violence against adult males tend to be both male and female, whereas perpetrators of family violence against adult females are mostly male.
- 61 per cent of women had children in their care
- Aboriginal women hospitalised is 34 times more
- More than one million children in Australia are affected by family and domestic violence.

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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 speakers are most welcome. Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost.

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RDMA's Christmas Celebration 2016