RDMA
RDMA & NLMA's Joint Newsletter

Newsletter
MARCH 2017

ANZAC Veteran's Stories Roy Cornford's Story AIF 2/19 Battalian

See Where We Work & Live on page 20.
http://anzacportal.dva.gov.au/veterans/stories/roy-cornford

President's Report Dr Kimberley Bondeson

This March has been a funny month. We have not had a proper wet season, and the cyclone season seems to have missed us. There were a couple of cyclones that crossed with Western Australian coastline, but did not seem to do much damage.

It seems that the Peninsular Region is quite sheltered from the weather, we have not had any prolonged raining or storms in this area.

The new American President, Donald Trump, is making waves in his new role, but still has not been able to build the fence between America and Mexico. He is also having trouble with legal challenges to his unfavourable immigration policy, which is to refuse visas to people from certain countries. How this unfolds will be interesting.

In Australia, there are murmurs that President Trumps deregulation of America's drug approval process could affect us, with a much larger number of unproven new drugs entering the market. For some reason, President Trump feels that the FDA approval process is ''too slow and burdensome'', and he wants to ''slash the restraints''. I hope he does this carefully, as often, only large trials will show up adverse effects, which are not seen in smaller trials.

One of my patients has just come back from Las Vegas in America, and tells me that Marijuana is now legal in that city. She commented that in the streets, all she could smell was the smell of Marijuana. In Australia, we have just seen changes which allow medical Marijuana. Is this the beginning of what we are now seeing in America? Will this be Australia in 10-20 years' time? The current system being developed in Australia seems to have constraints on it, but very few of my patients see it that way. Even one of my 79 yo patients, who was going in for an operation, asked if she could have some medical Marijuana for pain relief when she came out of hospital, as she was worried she would be in pain.

And whilst we have a new Federal Health Minister, Mr Hunt, he is yet to make any significant impact on the medical community, or make any definite statements about lifting the Medicare rebate freeze. However, it would appear that that Medicare rebate freeze is now being felt in the public hospital system, with an increase in the number of GP patients presenting at the local hospital A & E departments. This has been absolutely predictable.

I would also like to give a warm welcome to all the new Interns and Doctors-in-Training from the local Redcliffe and Caboolture Hospital, and hope to see them as a regular feature at our Local Medical Association monthly meetings!

Kimberley Bondeson,

RDMA & NLMA's Joint Newsletter

Welcome from

Dr Robert (Bob) Brown

President Northside Local Medical Association

Note: Doctors in Training
RDMA Membership is Free
RDMA Meeting Dates Page 2.

QML Pathology
Specialists in Private Pathology since the 1920s
REDCLIFFE LABORATORY
Partnering with Redcliffe & District Local Medical Association for more than 30 years.

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

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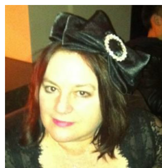

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RDMA 2017 MEETING DATES:

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 April 2017

Email: RDMANews@gmail.com

W: www.redcliffedoctorsmedicalassociation.org

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For all queries contact Graham McNally Meeting Convener: Phone: (07) 3121 4029
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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 28th March 2017

RDMA Meeting for 22.02.17
Dr Wayne Herdy, RDMA Vice President introduced the Sponsor Representative CPAP Direct's Managing Director Mr Brice Perron. Mr Perron introduced the Speaker Dr Andreas Fiene, Thoracic, Transplant and Sleep Physician whose topic for the evening was An Update on Respiratory & Sleep Medicine.

Below:
1. CPAP Direct Poster
2. Speaker Dr Andreas Fiene,
3. CPAP Representatives and Speaker: Dr Andreas Fiene, Brice Perron and Ms Lauren Valz.

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Tuesday 28th of March 2017**
TIME: 7pm for 7.30pm
VENUE: Regency Room – The Ox, 330 Oxley Avenue, Margate
COST: Financial members - FREE
Non-financial members $30 payable at the door.
(Membership applications available)

AGENDA:

7.00pm	Arrival & registration
7.30pm	Be seated – Entrée served Welcome by Dr Kimberley Bondeson - President RDMA Inc
7.35pm	Sponsor: Bayer
7.40pm	Speaker: Dr Jason Butler - Haematologist BMT/Clinical Haematology Unit, Cancer Care Services RBWH Topic: Deep issues of the venous kind
8.15pm	Main meal, question time
8.40pm	General business, dessert, tea & coffee

RSVP: By Friday 24th of March 2017
(e) RDMA@qml.com.au or (ph) 0466 480 315

Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology PUB/MR/1330, version 1 (Jan-16)

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Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 26th of April 2017**
TIME: 7pm for 7.30pm
VENUE: Regency Room – The Ox, 330 Oxley Avenue, Margate
COST: Financial members, interns, doctors in training & medical students - FREE. Non-financial members - $30 payable at the door. (Membership applications available)

AGENDA:

7.00pm	Arrival & registration
7.30pm	Be seated – Entrée served Welcome by Dr Kimberley Bondeson – President RDMA Inc
7.35pm	Sponsor: BioSCL
7.40pm	Speaker: Dr Tim Grice, Pain Management Physician & Specialist Anaesthetist. Topic: Chronic Pain Management - Time to Rethink your Approach
8.15pm	Main meal, question time
8.40pm	General business, dessert, tea & coffee

RSVP: By Friday 21st of April 2017
(e) RDMA@qml.com.au or (ph) 0466 480 315

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Job Vacancy

A full time or part time Family Doctor for the Narangba Family Medical Practice (www.narangba-medical.com.au) as one of our doctors left to specialise.

We are a three doctor, fully computerised, non-bulk-billing practice established since 1986 in an outer, semi-rural northern suburb of Brisbane.

Contact: Dr Peter C. Stephenson,
Email: PCS1@narangba-medical.com.au
Mobile: 0403 151 602.

Practice Phone & Location: Phone: 07 3886 6889, Opposite the Narangba Railway Station, Main Shopping Centre, beside the Narangba Pharmacy.

Street Address: 30 Main Street, Narangba Q 4504.

Postal Address: P.O. Box 3 Narangba Q 4504

2017-2019 Triennium Audit Registrations are Open

Sign up for audits now available:

Dysglycaemic States & Diabetes Mellitus Audit (NEW)
- Identify, monitor & review patients with Dysglycaemic States.
- Monitor compliance in patients diagnosed with Diabetes Mellitus type 1 & 2.

Surgical Skin Audit
- Assess your skin specimens according to:
  - Identification
  - Detection rate
  - Diagnostic accuracy
  - Histological accuracy
  - Overall treatment rates

Registration is simple, please speak to your Medical Liaison Officer, contact the Education team via email **education@qml.com.au** or phone **(07) 3121 4539.**

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QML Pathology

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AMAQ BRANCH COUNCILLOR REPORT
DR WAYNE HERDY, NORTH COAST COUNCILLOR

MANAGEMENT OF THE ADDICT OR SUSPECTED ADDICT AT FIRST PRESENTATION.

MANAGEMENT OF THE ADDICT OR SUSPECTED ADDICT AT FIRST PRESENTATION.

I have an idiosyncratic practice that caters for marginalized patients, including drug addicts, and for patients on long-term opioids for pain who are in that grey area between genuine pain and long-term habituation.

I have had a high level of exposure to new presentations of casual patients seeking controlled substances, some legitimate, some less so.

Over the years, I developed a protocol for reducing the chance of my being ripped off by addicts seeking substances of abuse. Nothing is foolproof, but like everything else in medicine the concept is to tip the balance of probabilities towards the outcome

Drugs sought include opiates, benzos (one favourite, alprazolam, is now S8 and I am thankful that the recent PBS restrictions have made it almost impossible to prescribe), ADHD drugs (Ritalin etc), and prescriptions for pseudoephedrine or weight loss drugs. NEVER prescribe pseudoephedrine (but I do offer nasal decongestant sprays which don't seem to be as popular).

Prescribers should exercise special caution if the patient requests a non-PBS private script. Addicts who are doctor-shoppers know these are not tracked by the (Commonwealth) Doctor Shoppers Hotline, but they are not aware that they are still tracked by (State) MRQ.

It is easy to be misled by stereotypes, eg tattoos & dreadlocks vs business shirt & tie.

Appearances can be deceiving. And I am not easily swayed by tears and histrionics.

CONTACT THE USUAL PRESCRIBER.

This is not usually practicable. The conventional story is that the usual prescriber is unavailable for all sorts of reasons which may or may not be legitimate, and failed to make provision for ongoing scripts (it's always the doctor's fault of course). But if you can phone the usual prescriber, you can place yourself on firm grounds early in the process.

OBTAIN GOVERNMENT PHOTO IDENTIFICATION.

If the patient does not have good photo ID, this is always good reason to refuse a script for controlled substances. The driver's licence does not have to be current, it just needs to be legible with a photo that looks like the person in front of you. Non-government ID is not good enough – anybody can walk into a sporting club and give a name to get a photo ID card. Non-photo ID (Medicare card, pension card, credit cards) do not identify the person who offers them. It has to have a good photo to identify the person.

Record the type of ID and any number on the ID card.

PHONE MRQ (MEDICINES REGULATION & QUALITY) 33289890

A State government check. The number is available 24/7 but the main office is open only during government business hours.

MRQ will advise whether the patient has

a. Been on QOTP (Queensland Opiate Treatment Programme) – if so, any prescriber must have prior approval of MRQ before prescribing any controlled substance. This usually is reason to refuse a script.

b. Had any approvals – if current, should refer to doctor who holds the approval.

c. Had any reports – meaning that another prescriber is or was prescribing controlled substances over 2/12 – the doctor should refer to that prescriber.

d. Had any other enquiries recently from other doctors – a reasonable marker of a doctor shopper.

e. Had any S8 scripts in a 3/12 period – but they are 1/12 in arrears.

Record that you have enquired with MRQ (and they will also record your enquiry).

PHONE DOCTOR SHOPPERS HOTLINE 1800 631181

A Federal government check.

Continued on Page 6

DR WAYNE HERDY, NORTH COAST COUNCILLOR

Number available 24/7, registers only PBS scripts and misses private scripts. But it is a national database and reasonably up to date, so it catches interstate travellers. The criteria are fairly loose, so some doctor shoppers can escape the net, but it is pretty reliable.

DSH will advise whether the patient has been identified under (fairly generous) criteria – but can still raise red flags if there are significant numbers of prescribers or significant numbers of target items.

Being identified as a doctor shopper does not equate to fraud or addiction – a lot of patients meet the criteria by seeing multiple doctors in the same practice, or by getting multiple prescriptions for target items which are not substances of abuse.

I always get a hardcopy faxed if the patient has been identified under the criteria.

STAGED DOSING

If concerns persist, arrange for staged dosing – daily, twice-weekly, weekly, with or without the pharmacist supervising some or all doses. If prescribing patches, get Fixomull applied over the patch, and have the patch replaced by the pharmacist (no old patch, no replacement patch). An interim measure until more information can be obtained from previous prescribers or pathology or imaging reports. If the patient objects to the added cost, or to the need for frequent attendances, stiff bikkies – do you want the script or not?

BOTTOM LINE.

As I said, nothing is foolproof, and even with this protocol you will get caught occasionally, but not often. If you follow these steps, and record each step, then you are as safe in your prescribing as you can hope to be.

It looks like an onerous burden, but for most patients it is a 5-minute process. And at the end of the day, you will have the opportunity to safely prescribe something that might really be looking after the patient's best interests. And isn't that what medical practice is all about?

Wayne Herdy
Branch Councillor
North Coast Branch

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Phone 07 54915 666
Fax: 07 54915 933
Email: admin@maudstreetmedical.com.au

MANAGEMENT OF THE ADDICT OR SUSPECTED ADDICT.

Drugs sought include opiates, benzos (alprazolam is S8), ADHD drugs, pseudoephedrine. Exercise special caution if the patient requests a non-PBS private script. Addicts who are doctor-shoppers know these are not tracked by the (Commonwealth) Doctor Shoppers Hotline, but are not aware that they are still tracked by (State) MRQ.

Do not be misled by stereotype, eg tattoos & dreadlocks vs business shirt & tie.

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Get hardcopy faxed.

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If concerns persist, arrange for staged dosing – daily, twice-weekly, weekly, with or without pharmacist supervising some/all doses. An interim measure until more information can be obtained from previous prescribers or pathology or imaging reports.

BULK BILLED Sleep Studies | **BULK BILLED** Lung Function Testing
Echocardiography | Stress Tests | Blood Pressure Monitoring

Northside Heart & Lung at Cadogan House, Nundah, has been treating locals and Brisbane residents since 2013.

The clinic offers a number of services, including lung function testing, sleep studies, cardiac stress tests and echocardiograms. The lung function testing and sleep studies are bulk billed, so there is no cost to patients, and includes analysis and reporting by the highly qualified team of specialists.

NHL's unique practice model combines the full range of cardiac, thoracic and sleep services, including access to the latest developments in cardiothoracic medicine through our trials centre.

Patients are diagnosed and treated efficiently and effectively, with comprehensive follow-up and communication with their GP.

With friendly, personalised service and free parking, the Northside Heart & Lung clinic is able to provide the best treatment for respiratory, sleep and cardiac issues.

Dr James Douglas
Sleep &Thoracic Physician

- Long term non-invasive ventilation
- Neuromuscular disease
- Insomnia
- Restless legs syndrome
- Parasomnias
- Narcolepsy

A/Prof Dan Chambers
General & Transplant Thoracic Physician

- Chronic cough
- COPD
- Interstitial lung disease
- Advanced lung disease
- Bronchiectasis
- Lung transplantation

Dr Andreas Fiene
Thoracic, Transplant & Sleep Physician

- Chronic respiratory illnesses
- Breathing related sleep disorders
- Consultations available at North Lakes Day Hospital

Dr Andrew Small
General and Interventional Cardiologist

- Chest Pain Syndromes
- Coronary Artery Disease
- Coronary Angiography and Angioplasty
- Valvular Heart Disease
- Hypertension.

Dr Mugur Nicolae
Cardiologist

- Adult Congenital Heart Disease
- General cardiology
- Echocardiography
- Percutaneous Pulmonary Valve implantation.

Northside Heart & Lung | Cadogan House, 1382 Sandgate Road, Nundah | Ph 3635 8400

AMAQ BRANCH COUNCILLOR REPORT
DR KIMBERLEY BONDESON, GREATER BRISBANE AREA

MEDICARE REBATE FREEZE, MEDICAL GRADUATE NUMBERS ANDS TRAINING PLACES

A continuing big issue is the Medicare Rebate Freeze. This is affecting all doctors in private practice, and is now affecting the A & E Departments in the public hospitals, which are being packed with GP type patients.

There also appears to be a lot of media based on Specialists not bulk billing, and on differences between specialists fees.

My comments to the government are that if they want specialists to bulk bill, then they need to make the Medicare rebate sufficient to cover costs. If the rebate covered this, then most doctors would accept it as payment. As it stands, the rebate is simply not enough to cover costs of keeping the doors of a private practice open.

Once a specialist is in private practice, as is any private practice doctor, the government has no jurisdiction over what they charge. The Medicare rebate freeze is in place, but there is no freeze on staff wages, rent for premises, or other costs of running a practice.

I think most patients have some understanding of this, as some rebates for specialists are $75.00 for a 45 minute consultation and this does not cover the receptionist wages, rent for the premises, computers, etc.

And the last time I had to get a plumber to fix a leak in my bathroom, I was charged $275.00 plus parts, for 20 minutes work. As I needed a working toilet, the bill was paid immediately.

The Federal Health Minister, Mr Hunt, has not yet made any formal statements about reversing the Medicare rebate freeze.

This is concerning, and makes one think that it is unlikely, until the government is put in such a position that they are forced to.

This may occur when the costs of running the public hospitals reaches such highs, that the General Practice and Private Specialist workforce are actually seen as a cost saving measure, and the Medicare rebate freeze is lifted, simply to allow private practitioners to bulk bill in large numbers again.

Another vital part of our profession is the teaching of junior doctors.

Australia is now producing enough medical graduates, but there is a shortage of internships and post-graduate training places.

In Western Australia alone, they graduated 3484 medical students in the year 2016, compared with 1660 medical students in the year 2000.

However, in 2016, there were not enough internship places for the graduates, and not enough training places.

This is going to continue Australia wide, and must be addressed by the government.

Sincerely

Kimberley Bondeson

AUSTRALIAN MEDICAL ASSOC PRESIDENT
Dr Chris Zappala

Members' Update

AMA Queensland has recently released our Health Vision Part Five – Care at the End of Life. The Health Vision is a five-part document, released in stages over the last two years starting at public/preventative health, moving through education and workforce to now end-of-life care. We can be immensely proud of this work. It has helped shape policy thinking and advocacy over this period.

Palliative care as a specialty, I think, is still evolving. One example of this is the difficulty in achieving a unanimous definition of what palliative care is when you ask people – including palliative care physicians. There's also the curious tension between managing symptoms, supporting patients and families, and assisting in directing care versus this somewhat arbitrary threshold of only helping patients estimated to be within three months of the end of their life.

As our population ages, and complex, co-morbid chronic disease is more common, it becomes obvious that many patients with difficult care requirements are going to need more involved palliative care assistance.

The model of relatively unidimensional, pre-terminal, cancer patients with pain who have a semi-predictable trajectory is superseded and prescient policy planning is required.

Palliative care is now definitely more complex and more involved, and the patients are 'sicker' for longer. At the heart of our intent in making the fifth (and last) part of our Health Vision is to help point policy makers in this direction and convince them of the exigency.

There is no question palliative care funding broadly needs to be increased. There are many facilities around the state managing with lean or negligible resources – both in public and private sectors. There remains a dearth of not just physicians, nurses and allied health, but also physical facilities.

Moreover, as patients become more complex, e.g. need high levels of supplemental oxygen or greater pharmacologic and nursing support to promote comfort from itch, dyspnoea, nausea, depression, anorexia etc., then skill, expertise and facilities will need to evolve to accommodate this.

I think it is important and timely for the profession to work with the government to augment and evolve palliative care services but also to promote understanding of advance health care planning and end-of-life care.

One of the significant potential benefits of the MyHealth record, I've been able to understand, is facilitating easy access to an advance health directive regardless of where the patient is seeking care. As we know, patients and families always manage better when they have discussed these issues, when comfortable and able to do so with time to ponder and consider options.

Unfortunately, doctors themselves have difficulty discerning the best time to open this discussion with patients – it's definitely not easy. If we strive to make it a more routine part of care, then hopefully a great deal of the apprehension felt by all parties decreases significantly. Not only therefore does the community have to develop their comprehension and comfort with advance care planning – but so do all doctors!

A concern I currently have is that access to services and professional assistance is somewhat dependent upon socioeconomic status. My observation is that patients who are well educated and ask thoughtful questions are much more accomplished at navigating the health care system and achieving good outcomes, including in terms of end-of-life care.

I can contrast patients known to me with Idiopathic Pulmonary Fibrosis or Motor Neurone Disease who have very different end-of-life experiences, significantly because of this variability. My hope, therefore, is that as we all become more proficient at advance health directive planning and end-of-life care, we diminish some of the inequity derived from variable health literacy, education and affluence in this critical phase of caring for our patients.

Human resources are only a part of the current deficiency in service provision – capital expenditure must be planned for and a commitment made.

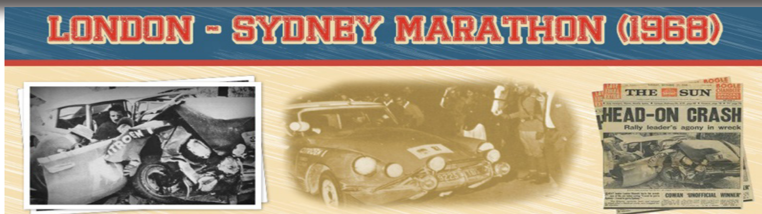
Continued on Page 11

MEDICAL MOTORING

WITH DOCTOR CLIVE FRASER

Safe motoring,
doctorclivefraser@hotmail.com.

“London to Sydney - By Any Means



The 1968 London to Sydney Marathon. It’s been almost 50 years since an adventurous group of drivers in 98 cars set off from London on a long road race to the Antipodes (aka Sydney) on the other side of the world. The idea for the race came from the owner of the Daily Express Newspaper who reasoned that the stagnant UK economy could be bostered by the world-wide attention that the race would create. He put up £10,000 in prize money and off they went.

The rules were simple. Go as fast as possible and try to get to Sydney first. Repairs could be undertaken en route, but no one was allowed to touch their vehicle whenever it was being transported by boat. The field was made up of a range of vehicles from Hillman Hunters to Falcon GTs and the drivers were as diverse as privateers and seasoned rally drivers such as Andrew Cowan.

I was ten years old when the race was run and I recall being mesmerised as I followed the field across the globe. After all, this was all before Apollo 11 and man setting foot on the Moon.

There were still remote places on Earth and National Geographic maps were still being used for navigation. Unbeknown to me a family from Australia were making the same trip from London to Sydney in a recently purchased Kombi van. Their route would be more circitous taking them first to Norway, across Scandinavia and down through Europe into Spain. From there they were finally heading in an Easterly direction towards the Middle East and onwards.

I recently met the driver who is not far off becoming a Centenarian. He has so many stories to tell and I had so many questions to ask. For starters, ”Did the Kombi break down?” The answer being, “No, never”. “Did you have any dramas on the trip?”
The answer being, ”Only in Afghanistan!” No surprises there I thought, after all even today Afghanistan is still a remote and dangerous place. “Oh no, not at all”, I was told. “We’d camped for the night in a field. We were just about asleep when there was a knock on the window. It was a police officer. He told us that there’d been some problems between a local tribe and another traveller recently. He thought it would be safer if we camped in the police station compound, which we did”.

DAILY EXPRESS DAILY TELEGRAPH
LONDON-SYDNEY MARATHON

“What was the highlight of the trip?” I asked. “The roads, how great the roads were, in Afghanistan”, came the reply. I thought I’d misheard the last sentence. Afghanistan and great roads, could that be possible?

Well, yes. Between 1960 and 1967 the US Army Corp of Engineers built 2,700 miles of paved highways in Afghanistan.According to my research the purpose of the regional transportation project was peaceful with no mention of the politics of the Cold War and the northern Russian neighbours. The construction of just one highway between Kabul and Kandahar would shorten the journey from 10 days to six hours.

I’m not sure how many of the fifty year old highways still remain, but since November 2016 they are being re-built again with the US stating that, ”The most effective weapon America possesses in the war on terrorism may not be its military capacity, but rather rural roads and access to technology”. Andrew Cowan won the London to Sydney Marathon in a Hillman Hunter and that model continued production in Iran until 2005. My almost Centenarian friend also got to Sydney and is still running his marathon.

Safe motoring, Doctor Clive Fraser

This is harder to achieve, but in an election year, it is something I believe the profession should ask of all politicians.

Acute medical wards are not the best places to care for dying patients in many circumstances but finding a palliative care facility to accommodate patients with even minimal medical care requirements beyond pain relief, can sometimes be a challenge. Moreover, if you have a young patient who is dying and/or has complex care needs, frequently they have nursing and physical care requirements that exceed what can be offered in the home but simultaneously, no access to aged care facilities or other institutions if they're not about to die imminently.

Complex care requirements might be that they have a tracheostomy, the patient might require bilevel ventilation or they might require high-flow rates of supplemental oxygen – to use examples in my field.

Many facilities balk at accepting care of these slightly more complex and, sometimes, younger patients. By contrast, the need from such patients is growing without any recognition that there is this increasing unmet need amongst this vulnerable group of patients.

I am very proud that AMA Queensland has convened a working group to develop a planning document to help doctors, families and patients discuss end-of-life care desires, and planning for children and young adults with a terminal illness.

Similar documents exist overseas but it was identified that a gap existed in Australia in this space. The working group, chaired by Dr Anthony Herbert, Director of Palliative Care at Lady Cilento Children's Hospital, is developing a statement of choices for this sub-group of patients also.

Our hope is this will reflect the adult document recently introduced in Queensland Health and become just as useful in time. This is one example of how our profession can lead positive change and, in cooperation with other health care providers, manage to make life for our patients a little easier and better.

Dr Chris Zappala
AMAQ President

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HOW TO USE THE HEALING POWER WITHIN

By Dr Mal Mohanlal

Do you know that your body has remarkable healing powers? Every person is born with these powers so that when you cut yourself, that cut will heal itself, without a doctor or any medicine if you keep it clean and protected. What will happen if you keep scratching it or keep it dirty? Will it heal? Surly not; it will get infected and get worse.

So you see when you damage or injure yourself Mother Nature wants you to get better straight away and will start healing you, if you will provide the right conditions. Same thing happens when you catch a virus or some other illness, Mother Nature will instantly start healing you.

This healing power in every one of us resides in our immune system which is under subconscious control. Therefore how you influence your subconscious mind has a tremendous effect on your state of health. Remember your perceptions are producing good or bad chemicals in your system depending on how you are viewing the world.

Hence, when you are happy you are producing all the good chemicals in your body. This boosts your immune system and thus increases your protection against illness. However, when you are stressed out, depressed, miserable and run down you are producing all the negative chemicals and your immune system becomes weak so you become susceptible to illness.

Hence if you are suffering from any illness, injury or disease, acute or chronic, it means that your immune system is not coping and is run down. It means you have allowed yourself to become susceptible to illness. Is it not therefore important for you to straighten out your perceptions so as to make your immune system strong again? This means you should learn how to harmonise and manipulate your subconscious mind.

This is a consumer world where the ego is supreme and the individual is exploited to the maximum leading one to believe that the cure to your disease or illness lies outside you, and a doctor or someone else cures you? Well to tell you the truth, that is a false perception.

Of course when you are sick doctors are the first line of call because they are the one who are trained to diagnose and treat your illness. But after they treat you and prescribe certain medications, it is what you do with yourself 24 hours a day that counts.

When doctors treat you and prescribe certain medications, what they are doing is providing the right conditions for you to help Mother Nature cure yourself. That is, they are helping your immune system to fight the disease. For example, when they prescribe antibiotics, they try to kill off the bacteria that are causing the disease so that your immune system can heal you quickly.

So you see that if you are suffering from some acute or chronic illness you really have no choice but to use the healing power within you to heal yourself. Do not think that someone else is going to cure you.

As I have said before, our perceptions are magical. You have to use that power of perception to change things around you in your lifestyle etc. to improve your general health to boost your immune system. So if you are a smoker clearly you should stop smoking, if you are a drug addict you should stop using the drugs, if you an over-weight person you should eat less and lose weight. If you are stressed, anxious or depressed you should try to resolve the problem and harmonise yourself with the world around you. If you are fearful of anything, you should get rid of the fear. Fear is the worst enemy of man. When one is afraid, one produces a lot of negative chemicals in the body.

Now please do not say that you have no will power. It has nothing to do with will power but everything to do with perceptions. If you put your finger in the fire, do you say you need will power to keep away from it? Please become aware of how you talk sense and nonsense. It is quite hypnotic. It affects your subconscious mind and can make you stupid. Always talk sense not nonsense, because our subconscious mind reacts to words not the meaning of the words. If you keep saying “I can’t help myself” you will really find yourself helpless as if you have no control over yourself.

When you say “I can’t help myself” what you really mean is “I do not want to help myself”.

Clearly you should be acquiring some self-knowledge and aiming at becoming physically and mentally fit so that your immune system has a chance to be become strong again enough to heal and cure you.

Please remember that healing always take place from within. At any given **Continued on Page 13**

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moment our body is in fine equilibrium with the environment we live in. There is intelligence at work and is active in every cell of our body not just our brain while we are alive. Each cell knows its function and knows what to do. One minute one can be quite happy and healthy, and the next minute one can be struggling for life. Such is a precarious nature of our existence. However, we all take this for granted in our daily routine of life until something happens, and then we are reminded that we are mortals after all.

Also please understand the fact that you are born in this body and die in this body. It is not a consumer item. You may be the prettiest or the ugliest person on earth, it does not matter. You may change your sex but whatever you do, you are stuck with it. It is like a car which takes you from point A to point B. If anything happens to this body of yours, you are grounded. Like a car you cannot just trade it in and get a new body. You may be able to replace a few parts, but that's all.

So it is your responsibility to look after this body of yours, no one else's. If you do not care, why should anyone care for you? Please start thinking rationally and wake up to yourself and the powers within.

If you are not interested in your own health and in learning about your own mind and understanding the powers within you, do you think anyone in the world will care?

You are the writer of your own destiny and the cure to your illness lies inside you and not outside you. No matter what or who you are, acquiring self-knowledge and coming to terms with your hopes, fears and desires is the first step to healing yourself from within. So please take command of the situation and become the master of your own destiny.

Read the "The Enchanted Time Traveller – A Book of Self-knowledge and the Subconscious Mind" and learn how you can use your own powers of perception, awareness and insight to help you heal and transform yourself.

Visit Website: http://theenchantedtimetraveller.com.au/

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REDISTRIBUTION OF MEDICAL SCHOOL PLACES NOT THE SOLE SOLUTION FOR RURAL MEDICAL WORKFORCE - AMA

The AMA believes that while Australia now has sufficient medical graduates and medical school places to meet current and future needs, greater funding for prevocational and specialist training places is needed to ensure an adequate flow of fully-trained doctors, especially to rural and remote areas.

In a submission to the Department of Health, the AMA has provided strong comment on the Government's assessment of the distribution of medical school places across the country.

Australia has seen dramatic growth in medical student numbers, with around 3,700 domestic and international students now graduating each year. This compares to 1,426 graduates per annum in 2002.

AMA President, Dr Michael Gannon, said today that Australia currently has about the right number of medical graduates and medical school places.

"Our view is consistent with workforce modelling prepared by the former Health Workforce Australia and, more recently, the Department of Health," Dr Gannon said.

"The clear challenge for the Government is to develop programs to encourage doctors to work in under-serviced areas, including rural and remote Australia.

"While the AMA is open to the redistribution of medical school places – shifting them between medical schools – it will not solve the problem in isolation.

"Any redistribution must be backed with funding for more downstream prevocational and specialist training places in country Australia.

"Rolling out more training in rural and remote areas will also require increased Government funding for supervision, mentoring, infrastructure, and adequate and appropriate clinical experiences.

"Any proposals to redistribute medical school places must be evidence-based, not driven by short-term political expediency.

"We know that early and continuing exposure of medical school students to rural health experiences, and measures to encourage students from regional and rural areas to enrol in medical schools, are the most likely initiatives to increase the workforce in these areas.

"Current programs like rural clinical schools, enrolment targets for students with a rural background, and requirements for students to spend extended periods in rural clinical settings, are working and should be built on.

"Any approach to increasing Australia's medical workforce, especially for regional areas, must encompass all stages of the medical training pipeline.

The AMA submission is at https://ama.com.au/submission/ama-submission-assessing-distribution-medical-school-places-australia

The Medical Journal of Australia • MJA
MEDIA RELEASE

4.1 MILLION AUSTRALIANS REMAIN UNVACCINATED

DESPITE the high profile of legislation designed to combat the anti-vaccination lobby, and the availability of free vaccines via the National Immunisation Program, 4.1 million Australians remain unvaccinated, according to the authors of a Perspective published in the *Medical Journal of Australia*.

Lead author Dr Robert Menzies, from the University of New South Wales, and his coauthors wrote that measures like “No jab, no pay” and “No jab, no play”, and the abolition of the conscientious objection process, had caught the media’s attention, but that the “children of parents with ideological objections to vaccination are a small subset; the vast majority are adults”.

Three groups were of major concern, the authors wrote:

- Undervaccinated children: there are about 1.8 million children aged over 6 years in Australia. Over 90% have received all recommended vaccines by 12, 24 and 60 months. Of about 150 000 who were undervaccinated and unvaccinated, about 37 000 were registered conscientious objectors. Of the remaining 6.1%, most were incompletely vaccinated or unvaccinated for other reasons.
- Undervaccinated adolescents: three-dose completion of the HPV vaccine course in adolescent girls is currently 73%. “Based on HPV coverage for adolescent girls and applying that to a 2-year cohort of both sexes, we estimate that there are currently about 150 000 undervaccinated adolescents aged 13–14 years,” the authors wrote.
- Undervaccinated adults: “There are about 3.5 million Australians aged ≥ 65 years, all of whom are eligible for pneumococcal and annual influenza vaccines. Yet only 51% of this population had received both vaccines when last measured, reflecting a large gap between funded infant and adult vaccine program.”

“The most important factor influencing vaccination uptake in older patients is a recommendation from a health professional,” the authors wrote.

“Achieving high vaccination coverage in adults is challenging, given their greater mobility and diversity of settings. However, this is likely to be more successful in preventing disease than policies that sanction vaccine-hesitant parents.

“There is a need for governments, the media, providers and individuals to direct more attention towards the large numbers of adults who are unnecessarily susceptible to vaccine-preventable disease each year. Immunisation is just as important for adolescents, older people, those with medical risk factors, pregnant women and other high risk groups as it is for children,” the authors concluded.

Please remember to credit The MJA – this assures your audience it is from a reputable source

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Japan Ski Conference or Holiday

by Cheryl Ryan

Returning from our Japan Ski Conference and I am missing the food already. Our small group of 8 guests enjoyed dining on traditional foods including sea cucumber and many other raw and unknown ingredients.

We all survived the challenges of trying different foods on the palate. Our dining included traditional Japanese foods but also French, Chinese, Italian and plenty of other great cuisines.

The conference was based around Customer Service and Japan did not let us down. Their attention to detail on every level was nothing less than exceptional.

We travelled North of Tokyo to a more remote and less known resort called Appi Kogen. Very few western people present with only one English speaking instructor who was in demand from all of us.

The slopes ranged from green (suited to me) through to Black Runs and for people wishing to venture a little further there were plenty of people heading off piste through the forest. The sun was shining; plenty of fresh snow and the slopes were not too busy.

Our days were spent on the slopes and our evenings spent in a private dining room where we enjoyed some great discussions and debates on time management, customer service and corporate ethics.

Getting naked with total strangers may not be your typical holiday pursuit, but don't be shy. The Japanese perceive bathing as a great social leveller and revel in the anonymity that nudity allows.

The relaxation that follows a long soak after being on the slopes soon had me converted. However there is an etiquette that must be followed when entering. A shower is taken before, during and finally the mineral water is left on the skin and not to be wasted.

There is a small towel that is usually provided which is used when entering the area and then used for bathing but must not be taken into the water. Most of the ladies folded the towel and placed it up on top of their head.

Tokyo is always swirling with people and construction. New fads abound and the shopping and sightseeing is endless.

A trip to Tsukiji Central Fish Market with 60,000 people employed is a hive of activity and so many varieties of fish you will not recognise.

The Tuna Auction visit will see you rise at 3am to get entrance into the 120 people limited viewing area.

If you miss out a wander around the outside stalls is fascinating and hours can be passed.

Of course a visit to Japan would not be complete without a visit to the Sumo Wrestling held in January.

If seeing the large grunting and sweating bodies is not your thing then try your hand at a cooking class, enjoy a tea ceremony or gown yourself in a Kimono.

It all a lot of fun!

www.123Travelconferences.com.au

SUPERANNUATION CHANGES TO COME INTO PLAY ON THE 1st JULY 2017

Superannuation see's its biggest shake up since the simplified superannuation reforms in 2007. It has been well played out in media from budget night to when the proposed changes got the royal assent in November 2016, but how will these changes will affect you?

The Government is putting a limit on how much can be in a tax free pension. The amount which can be in a tax free pension come 1st July 2017 is $1.6 million per individual (To increase with CPI), to avoid any penalties there are two options if your current pension balance is in excess of the $1.6 million;

- Commute the excess back to accumulation phase (Where the super fund pays 15% tax on it's earnings)
- Withdraw the excess amounts out of the superannuation environment.

Certain questions have to be asked surrounding the $1.6million tax free pension cap:

- Are you in a position to rebalance your accounts with your spouse?
- Is the Governments Capital Gains Tax (CGT) Relief right for you? (Please note if you are setting up a Transition to retirement pension (TRIS) you can also use the governments CGT relief)

Are you currently setup on a Transition to Retirement (TRIS)? If so come 1st July 2017 your TRIS will lose its tax exempt status which it currently receives on its earnings. The questions which you may be asking are when will you receive those tax exemption benefits again? It will be the first of the following;

- Reaching your preservation age but under age 60;
    - Ceased employment & have no intention of being gainfully employed again.
- Over age 60;
    - Ceased employment
    - Have reached age 65

Is your overall balance above $1.6million in superannuation? Did you know this maybe the last financial which you can contribute an after-tax contribution.
The non-concessional contribution limits will be dropping post 1st July 2017 to $100,000 a year or $300,000 using the three year rule. If you are thinking about doing a big contribution into your superannuation fund this year, you may still be able to utilise the old caps of $180,000 or $540,000 using the three year rule.

Please discuss with your current accountant how much you can contribute into super prior to 30th June 2017 as this is dependent on numerous factors (Such as age, previous contributions, etc)
The concessional contribution cap will reduce down to $25,000 come 1st July 2017 regardless of age. What action has to be done?

- Review your current salary sacrifice agreements in place

To see an extensive list of superannuation changes please use the following link;
https://www.ato.gov.au/individuals/super/super-changes/

Super Choice

The Queensland Government has introduced legislation that will allow Queensland public servants (Such QLD Health) to choose to join another superannuation fund. The changes will take effect on 30 June 2017. For example this would allow a QLD Health employee to elect their superannuation guarantee to be contributed into a Self-Managed Super Fund (SMSF).

Article written by Paul Lewty. If you have any questions please give either Paul or Kirk Jarrott a call and mention this article. Phone 07 5437 9900

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MORE TRAINING FOR DOCTORS NEEDED TO IDENTIFY AND TREAT FGM SURVIVORS: AMA Position Statement on Female Genital Mutilation 2017

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Training for doctors in how to identify and treat patients who have undergone female genital mutilation (FGM) should be included in tertiary medical curricula, the AMA said today. Releasing the AMA's Position Statement on Female Genital Mutilation 2017, AMA President, and Dr Michael Gannon, said that while FGM is only practised in about 30 countries, and is illegal in Australia, Australian women are affected by the practice.

"The AMA uses the term 'female genital mutilation', or FGM, to reflect the severity of the practice," Dr Gannon said. "FGM is illegal in Australia, as is taking a girl or woman overseas to undergo the procedure. Its practice is shrouded in secrecy, and collecting comprehensive data on its prevalence is difficult.

"However, surveys indicate that up to one in 10 paediatricians in Australia have treated patients who have undergone FGM, and in 2010, the Royal Women's Hospital in Melbourne reported that it was treating 600 to 700 women for FGM-related complications each year. "These are only the women and girls who have sought care for their ongoing difficulties. There are significant cultural and practical barriers that may limit a survivor's ability to seek medical help for complications. "Women who have undergone the procedure may not regard it as mutilation, and doctors who provide care to these patients should use culturally appropriate language that the individual patient is comfortable with.

"The AMA recognises the need for increased training and education for doctors in identifying and treating women and girls who have undergone FGM, and recommends the inclusion of FGM training in tertiary medical curricula." FGM is practised to varying extents in about 30 countries throughout Africa, Asia, and the Middle East. However, changing migration patterns have seen FGM emerge in diaspora communities in countries with no previous history of the practice. "There is no medical justification for FGM, and it can have devastating, even fatal, consequences," Dr Gannon said.

"Survivors are likely to need significant, specialised medical care in the immediate aftermath of the procedure, and in the long term, particularly during pregnancy, birth, and the immediate postnatal period. "They are often left with lifelong medical complications, in addition to lasting psychological trauma. They may need reconstructive surgery, and pregnancy can present unique challenges. "It is important that health practitioners are aware of the clinical indications that FGM may have occurred, in order to correctly identify women and girls who may require specialist care.

"Someone who has undergone FGM may present with frequent urinary infections, chronic genital pain, or a reluctance to undergo routine examinations. Doctors should be particularly mindful of these symptoms when caring for patients from countries where FGM may be practised.

"Doctors and other health practitioners also have a valuable role to play in the prevention of FGM. If a doctor identifies an at-risk child, he or she has a responsibility to initiate a non-judgmental, culturally sensitive discussion with the parents. "Where possible, this discussion can be followed up with a referral to a specialist FGM education program. "If the health practitioner feels that the child remains at risk, he or she is bound by mandatory reporting requirements to inform appropriate child protection authorities."

The AMA Position Statement on Female Genital Mutilation 2017 can be read in full at https://ama.com.au/position-statement/female-genital-mutilation-2017. The Multicultural Centre for Women's Health is holding the 2017 National Forum on Female Genital Mutilation/Cutting (FGM/C) on Friday, 24 March, in Melbourne.

Background:
Female genital mutilation comprises all procedures that involve partial or total removal of the external female genitalia, or other deliberate injury to the female genital organs for non-medical reasons, most commonly carried out between infancy and age 15.

FGM is a harmful, internationally condemned practice that violates human rights, as well as numerous international laws and resolutions, including the United Nations Intensifying global efforts for the elimination of female genital mutilations resolution, which was co-sponsored by Australia. While some proponents of FGM cite religious custom as justification for its continuation, there is no mention of the practice in any major religious doctrine.

It is estimated that, globally, at least 200 million women and girls are living with the consequences of FGM. Immediate risks include infection, severe pain, haemorrhage, shock, urinary complications, and death. Long term complications include scarring, sexual dysfunction, chronic genital, reproductive, and urinary difficulties, as well as lasting psychological trauma.
23 March 2017

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ANZAC Stories: Roy Cornford AIF, 2/19 Battalian

http://anzacportal.dva.gov.au/veterans/stories/roy-cornford

Enlisted into the Second Australian Imperial Force (AIF) in September 1941 Roy Cornford was just a 19 year old labourer. He arrived in Singapore late in the Malayan campaign as a reinforcement for the 2/19th Battalion but he was fortunate enough to be evacuated from Singapore to Java a week before the city fell to Japanese force. Luck is a fleeting thing and his was not to hold. Roy unfortunately was taken as a Japanese prisoner when Java fell in March 1942.

Prisoners were transported back to Singapore and Roy went on to work in Thailand on the notorious Burma-Thailand Railway. In March 1944, Roy amongst a group of prisoners of war (POWs) in Thailand who were selected by their Japanese captors for transport to Japan to work as slave labour. Many delays were endured before the departure for Japan arrived and with it a tortuous trip from Thailand to Singapore began. Roy departed aboard the Japanese cargo ship Rakuyo Maru, part of a convoy bound for Japan from Singapore on 6 September 1944.

Roy's Story Part 1

All the men were packed and marched down to the docks. And when we got down to the docks there were two ships there. And one ship was to take 1500 prisoners; another was to take the other 800. Well there was about 750 Australians I think. And we were supposed to go on the ship that was to take the 800, but they marched us onto the wrong ship. So they had to make up the numbers of Englishmen on the same ship as us. And the other ship just had the 750 Englishmen on it.

When we eventually sailed, when we went aboard, we had to go up the gangplank and first they took on heaps of young Japanese people, injured Japanese soldiers, and then a heap of Geisha girls, and then they took us up. As we were going up the plank the Geisha girls were spitting at us.

We were taken on board, and first they put us all down in the hold.

But as you went on board you had to carry a big tube of rubber. This was about 18 inches by 18 inches and it had a handle on it and they told us that was our life preservers. But as you went up they packed all of them down in the hold. Of course that hold was full of rubber.

They put us all down below, and you had about two foot square for each prisoner and the bit of gear that you had. But after the ship sailed they relented and allowed so many hundred up on deck and I was one of the lucky ones that was up on deck. Well, you never got any better treatment or anything. It just meant more room for those down in the hold. And you only got one cup of water a day, but luckily on the second night it poured down raining, it just fell down. Everyone caught rain in their dixies and had a good wash and a good drink of water. And other days, to have a wash, they had a salt water hose going all the time and you'd go over there and get under that.

On 12 September, the convoy was attacked by a US Navy submarine 'wolf pack', consisting of US Ships Growler, Pampanito and Sealion. No ship in the Japanese Convoy carried any special markings as the Japanese government had made no application for safe passage of the ships as POW transports. The two ships in the convoy carrying POWs were the Rakuyo Maru and Kachidoki Maru, and they were sunk by the submarines. The American submarine crews had no way of knowing that Allied POWs were aboard the ships when they were torpedoed.

Continued next Edition Roy's Story Part 2