RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
MARCH 2018

Thai Burma Railway and Hellfire Pass continued:

See Where We Work & Live on page 20.

http://anzacportal.dva.gov.au/history/conflicts/thaiburma-railway-and-hellfire-pass.pdf

President's Report Dr Kimberley Bondeson

Welcome to March, 2018 and the beginning of autumn. And the return of the wet season, which we have not seen for a number of years! The increased rain and stormy weather can be put down to two cyclones, one which travelled off the eastern Australia shoreline, causing problems for New Zealand and New Caledonia, followed by another one which has just passed the coast near Darwin. Both were category 1 storms, edging towards category 2, but fizzed out. Not without bringing a lot of rain and damaging winds. Ingham in North Queensland experienced flooding in the town, which, unfortunately, they are used to over the years.

Flu season is traditionally seen in the months of July - September. Last year's flu vaccination was thought to be only 10% affective due to virus mutations. The flu vaccination takes 2 weeks to become protective, and only lasts for 3-4 months. Currently, in clinical practice, we are still seeing patients presenting with cases of influenza, something we have not seen at this time of year for many years. Chemist Warehouse are already advertising flu vaccinations, and advising to get in early. We can see this is going to cause a problem, and is contrary to medical advice, which supports May as the month which flu vaccines should be given. So "getting in early" is not going to do it. And if there are more virus mutations, then we could be headed for another horror flu season. Government supplies of a Super vaccine, licenced for the 65yo and older aged population, are only available from doctors, and from mid-April. It is not available on the private market.

On the news recently, I was saddened to see that the number one concern of parents for their children is cyber-bullying. This over took parental concerns about alcohol and drug abuse. Parents and schools are struggling to manage cyber-bullying, which is taking all forms in this digital age. Even texts between supposed friends can often lead to bullying, which is affecting children. Currently, one of the biggest issues is that there is no consequence for a child, who writes a nasty comment on line, often to a complete stranger. Parents are often not even aware what their child has been up to. I think that if parents are more concerned about this topic then about alcohol or drugs impacting on their children, then we need to take heed and develop a strong community plan to combat this. This topic is in the news recently, in response to some very recent tragic teenage suicides.

Talking of bullying and suicide, it would appear that the government and medical profession is in positive talks concerning Mandatory Reporting, and from all reports, is leaning towards the South Australian Model, which is exempt from Mandatory Reporting. A final decision is expected to be released in mid April, 2018. I would like to thank Dr Bill Boyd for making the journey to our RDMA February meeting, and to thank him for an interesting presentation and discussion. Well done Bill, and thank you again. I would also ike to welcome Dr Paul Bryant, who is the newest member of the Northside Local Medical Association Executive, and who has written an article for the joint RDMA-NLMA newsletter – one of many, I hope. Thank you Paul. Kimberley

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.

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

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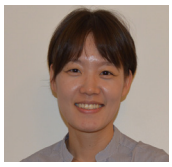

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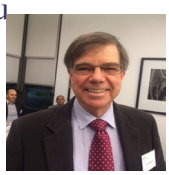

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RDMA 2018 MEETING DATES:

For all queries contact Emelia Hong Meeting Convener: Phone: (07) 3049 4444

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

Tuesday	February	27th
Wednesday	March	28th
Tuesday	April	24th
Wednesday	May	30th
Tuesday	June	26th
Wednesday	July	25th
ANNUAL GENERAL MEETING - AGM		
Tuesday	August	28th
Wednesday	September	12th
Tuesday	October	30th
NETWORKING MEETING		
Friday	December	7th

NEWSLETTER DEADLINE

Advertising & Contribution 16 April 2018

Email: RDMANews@gmail.com

W: www.redcliffedoctorsmedicalassociation.org

NLMA 2018 MEETING DATES:

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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	13th
2	April	10th
3	June	12th
ANNUAL GENERAL MEETING - AGM		
4	August	14th
5	October	9th
6	December	11th OR 14th

Next Meeting Date 28th MARCH 2018

RDMA Meeting for 27.02.18

Dr Kimberley Bondeson, RDMA President Introduced the Speaker for the night: Dr Geoff Harding, Topic Chronic Pain Management - Post Codine Rescheduling. Sponsor Mundipharma Reps Daniella Talbot, Ashliegh Zaeza, Helen Harvey.

Photo 1, Guest Speakers Dr Bill Boyd AMAQ President **Photo 2,** Dr Wayne Herdy Vice President RDMA

Photos from Left to right:
Photo 3. Dr Geoff Harding Speaker, and Daniella Talbot, **Photo 4** Ashliegh Zaeza, Geoff Harding, Helen Harvey & Daniella Talbot. New Members: **Photo 5. (**New) Aneisari & Navana Weerasinghe, **Photo 6.** Jackie Byrne, **Photo 7.** Lisa Hunt & Samual Rudstein, **Photo 8.** Rachael Laig, Bianca Kwan & Jeremy So, **Photo 9.** Matt Tatkovic, **Photo 10.** Paraban R

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 28th of March 2018**

TIME: 7pm for 7:30pm start

VENUE: Regency Room – The Ox, 330 Oxley Avenue, Margate

COST: Financial members, interns, doctors in training and 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: Redcliffe Hospital Palliative Care Unit, Introduction by Dr Darshit A Thaker.
7:45pm	Speaker: Dr Bruce Stafford, Director Palliative Care Unit, Redcliffe Hospital. Topic: "Do we really need Specialist Palliative Medicine?"
8:05pm	Speaker: Dr Sue Colen, Senior Medical Officer, Palliative Care Unit, Redcliffe Hospital. Topic: "Can we talk about dying?"
8:15pm	Main Meal served
8:25pm	Question Time
8.40pm	Dessert, Tea & Coffee served
8.50pm	General Business

RSVP: By Friday 23rd of March 2018
(e) RDMA@qml.com.au or 0413 760 961

INSIDE THIS ISSUE:

NLMA COMMITTEE MEMBER
Dr Paul Bryan, Vice President NLMA

An Update from Paul Bryan

Hi Members!

For those in the Redcliffe and Brisbane Northside Local Medical Associations whom I haven't met, my name is Paul.

I'm a new member of the Northside LMA Executive.

To give you some background, I'm a UQ graduate who has worked as a GP on Brisbane's Northside for the past 5 years.

For a few years prior to that, I worked as an intern and surgical PHO at The Prince Charles Hospital.

My family and I are proud to call the Northside home.

Like Kimberley Bondeson, I am a GP Representative on both the AMAQ Council and AMAQ Council of General Practice.

In these roles, we do our best to provide a primary care perspective on emerging issues in healthcare in the Sunshine State, particularly Greater Brisbane.

I'm also a representative on the

- RACGP Queensland Faculty Board, which guides Council on the policies and activities of the College in our state, and
- RACGP Queensland New Fellows Committee, a newly formed group that aims to provide networking, educational, and professional development events for GPs in their first 5 years post Fellowship.

I took on these representative roles because I consider myself a passionate advocate for junior doctors, general practice, and the medical profession in general.

The RACGP intends to take a more active role in advocacy for GPs going forward.

As such, it wants to establish closer relationships with its members to guide policy decisions.

As a member of the Faculty Board, one of my roles is to act as a conduit for the views of the RACGP membership, making sure those opinions are heard by the people who make decisions.

So, if you're a

- New Fellow who wants to get involved in some of our networking or educational events,
- a GP who has a compliment, complaint, or idea for the College,
- or a medical practitioner who wants to know more about the great work AMAQ is doing for doctors (or has ideas for how it could do so better)

Please don't hesitate to get in touch with me.

Sincerely

Dr Paul Bryan

Northside Local Medical Association

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Dr William Boyd M.B.Ch.B. (Dundee)

F.R.C.O.G., F.R.A.N.Z.C.O.G.,G.A.I.C.D.

AMAQ PRESIDENT'S REPORT

A Ship In The Harbour Is Safe - But That Is Not What Ships Are Built For.

(John Shedd 1859 - 1928).

This aphorism, which was quoted recently on very early morning ABC radio, has also been attributed to others including US Navy Rear Admiral Grace Murray Hopper. Furthermore it is common observation that ships kept in the harbour will tend to rust and rot. It is the promise of at least adventure, if not advancement, that encourages us to abandon the safe haven. The notion here is that while ships certainly face risk at sea, the end most often justifies the means.

Adventure yes and advancement possibly but there are times when we must put to sea to fend off the unwanted attention of those who would hurt us.

We as doctors have long been instilled by our teachers with exhortations to practice with professionalism, with honesty and with diligence. To most of us, these and other worthy attributes come instinctively such that we do not have to contemplate them repetitively. We actually know our job; we actually do 'get it'.

There is however those who would do us harm for their own ends.

The medical profession, for the most part admired by those who put their faith in us, is also a magnet for a set of detractors who, if nothing else, work to carve their careers in an obsessive, chronic rage which often appears to be driven purely by the money they can make. A significant portion of that rage is driven by a quest to control, command and subjugate doctors - to tell us where we will live and work, when we will work and how much we will be paid. Overlapping with that portion seems to be an undertow of jealousy.

Thus we are indeed in the midst of attacks on a variety of fronts, largely set in play by governments either directly or through their agencies. Such an agency becomes a nice little earner for those who are chosen. Adhering to those governments and agencies, like sucker fish, are the scavengers who are able to profit from convoluted health sector legislation and regulation much of which is self-serving.

Compliance, accreditation, licensing, CPD, insurance, medicolegal, quality assurance, governance - you name it. All provide employment which is paid for by your hard work. Yes we do need a symbiotic relationship with each of these to ensure the system works but collectively they have lurched from symbiosis to parasitism. Most of us are familiar with parasites of one description or another and the damage they do.

And so to those ships. Well we as a profession have a veritable flotilla of metaphorical ships in our associations and groups. Much of the time they do languish in the harbour receiving more or less maintenance and occasionally they put out in calm seas for recreation but the time is nigh for them to work together to fend off the onslaught. Those responsible for their wellbeing must be astute captains. They must be doctors hardened by experience and dedicated to the job in hand. The practice of delegation of responsibility for the destiny of the doctors to a non-doctor maintenance crew who would sail our ships by remote control from the safety of the harbours is costing us dearly.

The Australian Medical Association remains the single, most powerful, membership-based association in the nation. There are times however when all doctors would benefit by having their various representative groups coming together to add their combined weight to a common cause. There is nothing like a common cause to bring erstwhile estranged parties together.

The headlong flight to managed care, happening right now and being tackled full frontal by AMA, could be taken to be such a cause. I say all hands on deck and prepare to repel boarders.

Bill

Dr William Boyd M.B.Ch.B. (Dundee), F.R.C.O.G., F.R.A.N.Z.C.O.G., G.A.I.C.D.

Interesting Tidbits NATTY MOMENTS:

Funny One Liners

What do you get when you wake up on a workday and realize you ran out of coffee? ***A depresso.***

I used to breed rabbits. ***Then I realised they can handle it themselves.***

Google request: ***How to disable autocorrect in wife?***

Why are eggs not very much into jokes? ***Because they could crack up.***

What do you call the soft tissue between a shark's teeth? ***A slow swimmer.***

I went to see the doctor about my short-term memory problems. ***The first thing he did was made me pay in advance.***

Women usually claim childbirth is the most painful experience of their lives. ***Until they start stepping on Legos approximately three years later.***

Does your horse smoke? No. ***Well, then I think your stable is burning.***

What are a shark's two most favorite words? ***Man overboard!***

I ran into my ex in town yesterday. ***Then I ran over him and backed up to run into him again.***

Need cheering up? ***Start a fight with somebody when they have the hiccoughs!***

I don't think women should be allowed to have kids after 40. ***40 kids is way too much by any standard.***

What is Jesus' favorite food? ***Cheeses.***

What is written on a dentist's grave? ***He's filling his last cavity.***

Losing a wife can be very tough. ***Some may even say impossible.***

What is sticky and brown? ***A stick!***

CEO UPDATE:

AMA Queensland

LMA NEWSLETTER COLUMN – MARCH 2018

RACP computer based Basic Training Written Divisional exam

We provided a number of updates on next steps after the failed Royal Australasian College of Physicians (RACP) Computer Based Basic Training Written Divisional Exam on 19 February.

We are very pleased that we were in a strong position to work with RACP and other health stakeholders to support our trainee doctors through that very difficult time and saw sensible resolutions to many of the flow-on issues that inevitably arose.

We also worked with Queensland Health and the Hospital Health Service Districts (HHSs) around the state to ensure that roster changes, access to leave and other entitlements were provisioned for our trainee doctors ahead of the rescheduled exam.

It is noted that:

trainees will be refunded the full fees paid for this year's exam; and

trainees will not be financially disadvantaged as a result of having had to undertake the rescheduled exam.

RACP advised us they will conduct a review and we strongly emphasised the need for an appropriate terms of reference and genuine independence for the review process. AMA Queensland will prepare a submission to this review, using the extensive feedback and statements that our members have provided us.

All Registrars who are sitting an exam in 2018 are eligible for a 50% exam discount on their AMA Queensland membership. For further information about the exam discount, please email membership@amaq.com.au.

Jane Schmitt
Chief Executive Officer, AMA Queensland

Media release
Friday 9 March

New medical school not a healthy option for Rural Queensland

Today Central Queensland University announced its intention to open a new medical school.

The Australian Medical Students Association Rural Health (AMSA RH) Committee calls on the Queensland and Federal Governments to reject any new medical school proposals, on the basis that graduate numbers already exceed training places and the proposed location will duplicate existing federally funded Rural Clinical Schools.

Co-Chair of AMSA RH Nic Batten said: "Along with Charles Sturt, La Trobe, and Macquarie, yet another university is selfishly ignoring the message that Australia is currently producing too many medical students, and the evidence that an increase in student numbers is not translating to more rural doctors".

"The University of Queensland Rural Clinical School is already based in the locations proposed by CQU.

"UQ medical students train within the Central Qld Health Service at Rockhampton, within the Wide Bay Health Service at Bundaberg and Hervey Bay, and within the Darling Downs Health Service at Toowoomba.

"What will happen to these students and their opportunities for rural training if the new medical school is allowed to proceed?" Said Ms Batten.

"Many Queensland students, of both rural and urban background, want to become rural doctors, but the bottlenecks in training are hampering their ability to continue their careers in the country," said Ms Batten.

AMSA President Alex Farrell said: "CQU is joining a long line of universities pushing for unnecessary medical degree programs. This takes place in a training climate which is already flooded with graduates, whilst Charles Sturt and La Trobe Universities continue to push for a Murray Darling Medical School in NSW and Victoria."

"Medical student numbers have more than doubled in the past ten years. This has not been matched by an appropriate increase in the number of intern places, nor in speciality-training positions.

"It is estimated over 1000 graduates will miss out on training positions by 2030. Any new medical school will only exacerbate this oversupply without providing more doctors for country areas.

"The duplication of already existing rural clinical school infrastructure is a waste of money that will not increase the supply of fully-trained doctors in rural areas," said Ms Farrell.

Ms Batten said: "Rural areas are undersupplied by doctors, but if we're serious about creating more rural doctors we need to focus on real solutions.

"Our trainee doctors need rural pathways to continue their training in the bush, so that they can stay in the bush.

"To create rural doctors, we need the opportunity for more rurally-based Specialty training, and a concrete commitment from federal and state governments for the National Rural Generalist Pathway," said Ms Batten

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EHLERS-DANLOS SYNDROME AND PROLOTHERAPY
A CASE HISTORY
BY DR PHILIP DUPRE CONTINUED PAGE 12

EDS is a genetic disorder that causes weak connective tissue and therefore affects joints, skin and sometimes blood vessels. Joints become unstable, skin becomes lax and blood vessels fragile. It affects about 1 in 5,000 of the population to a varying degree. It also affects animals.

Generally, surgical treatment for these unstable joints is ineffective because surgery does not correct the underlying tissue fragility.

About 3 years ago, I was approached by the mother of Ashlee, a 15 year-old girl affected by this condition and having a problem with dislocating patellae. She was keen to know if prolotherapy might help her daughter. Prolotherapy involves the injection of an irritant solution, usually glucose, into areas of chronic pain in order to cause an inflammatory response. This initiates a healing process in the damaged soft tissue, and ligaments are strengthened. It is most commonly used for spinal pain with generally good results.

I had not heard of prolotherapy being used in Ashlee's situation but, in theory, injecting a sclerosant (concentrated 50% glucose mixed with an equal volume of local anaesthetic) into the medial joint capsule of her knee might tighten and strengthen the tissues and therefore stabilise her knee. She and her mother were keen to give it a try.

Her right patella had been dislocating about every other day for the past 6 months, so she was forced to wear a knee splint. Her left knee was doing the same. Initially, I infiltrated 2mls of the glucose mixture into the medial capsule of her right knee. Two weeks later she stated that her knee felt more stable, so 3mls were injected at this session. At 5 weeks' follow-up, after two injection treatments, she was able to discard her knee brace, and at 8 weeks she had stopped dislocating completely.

Meanwhile, as her left knee had the same problem it was also injected.

Two years after the initial treatment, both patellae had started to sublux but responded well to more injections.

In summary, her right knee stabilised after 4 treatments over 7 weeks but required two further injections 2 years later. Her left knee was stable 2 weeks after only one injection, but again required a booster 2 years later. It is now 6 months since her last treatment and Ashlee reports that both knees are feeling good.

About 18 months after her first knee treatment, she reported that her left wrist had been dislocating and this was demonstrable at the radiocarpal joint. In view of the reported success of treating lax cruciate knee ligaments with intra-articular glucose, I injected 2mls of glucose mixture into her left wrist joint. Two months later she stated that her wrist was about 60% improved. On this occasion I infiltrated 1ml of mixture into the dorsal capsule of her wrist joint. She was seen 6 months later and stated that her wrist had been good for 5 months following the last injection but was starting to sublux again. 2mls of mixture were again injected into her left wrist joint. Currently, 8 months after the last treatment, she is happy with the result, her wrist is stable with only occasional twinges of pain.

In retrospect I would in future only inject the dorsal capsule and if intra-articular injection was required only use 1ml of glucose mixture.

EHLERS-DANLOS SYNDROME AND PROLOTHERAPY – A CASE HISTORY

BY DR PHILIP DUPRE

CONTINUED FROM PAGE 11

During all this time, Ashlee's left shoulder had been dislocating anteriorly. This was painful and distressing. The problem was how to stabilise a global joint laxity. The original operations for anterior shoulder dislocation involved suspending the humeral head from the acromion by tendon graft or transfer and, bearing in mind this principle, I infiltrated Ashlee's postero-superior shoulder capsule with 2ml of glucose mixture. She has required four further injection treatments over a 13 month period and currently she says her shoulder is not dislocating at all, whereas, in the past it had been happening up to thirty times a day which was painful and very inconvenient.

In addition to all the above, she reported instability in her left ankle, both inversion and eversion. This responded well to a single injection into her medial and lateral ligaments.

In summary, this is only one case, the story of an 18 year-old girl with Type 3 Ehlers-Danlos Syndrome, who has gained significant improvement from a simple and inexpensive treatment over the past 2-and-a-half years. She is currently attending university and states that at this time (March 2018) none of her joints feel unstable, and she of course is very pleased with the results. She is unable to explain why her problems have generally been unilateral. She is right handed.

It is possible that prolotherapy may have a place in treating people with normal connective tissue who have joint instability, especially of the patella, but this will require further research.

BIBLIOGRAPHY
Reeves, K. D. and Hassanein, K. Randomised Prospective Double-Blind Placebo-Controlled Study of Dextrose Prolotherapy for Knee Osteoarthritis With or Without ACL Laxity. Alternative Therapies, 2000 Mar, Vol 6. No. 2, pp. 68-79.

Perceptions and Our Immune System

By Dr Mal Mohanlal

Continued P13

We live in a hypnotic world. This world out there is not for you to correct your perceptions. If you thought that way you would be terribly mistaken. The consumer world is there to exploit your hopes, fears and desires. It is there to distort your perceptions. It is for you as an individual to become aware and correct those perceptions.

Medicine is not an exact science but consumerism has influenced the medical profession to act in a way to give the public impression that medicine is indeed an exact science. Medicine is not a consumer item yet they go along with the notion that it is a consumer item. This way they can apply the same standards of measurement of quality that applies to any consumer item which of course further reinforces and distorts our perceptions into believing that medicine is indeed a consumer item. Politics is a game of distorting people's perceptions. Medicine is all about clearing up people's perceptions and improving their mental health. If the medical profession plays politics it means that they are also involved in distorting perceptions. Clearly they should stop playing politics and stop politicians turning medicine into a political football. They should be exposing politics.

Alas, I can see no hope of society ever improving its mental health without the medical profession clearing up its perceptions regarding the current role they are playing.

In my recent article "Mental Illness and Perceptions" I have pointed out how mental illness is related to our perceptions and it is increasing in every society in the world today. If we are to improve our mental health we have to clear up our perceptions. Quite clearly, from what I have stated above we cannot depend on the medical profession to do this. They have one of the highest suicide rates in society. Where is their credibility when it comes to their mental health?

So how do we go about clearing up our perceptions? I can only try to help you understand what happens in the mind from my own observations. If what I write makes sense then it should start clearing up your perceptions.

First of all let us understand what perception means. There is an observer (the ego) in our mind looking at the picture of reality in front of us. So whenever we open and close our eyes (blink) our eye momentarily fixes on a spot and

Perceptions and Our Immune System

By Dr Mal Mohanlal

takes a picture of reality. Perception takes place when the eyes are momentarily fixed and not while travelling from one fixed point to another. We are in actual fact taking a series of pictures of reality and it is our brain that interprets it as one continuous event.

In my mind, when I look at reality, I see it as a timeless dimension. When the observer in the mind and what is being observed become one phenomenon, which many of us experience from time to time without recognising it, you are experiencing that timeless dimension. Here there is no past, present or future. You are looking through a clear sheet of glass. It is only when you introduce words such as 'Oh how beautiful it is etc.…' that you step out of this timeless zone and quickly return into your own manmade time zone. The words just smudge that clean sheet of glass and distort the picture. Everyday all of us are experiencing reality. Our perception causes all sorts of physiological and biochemical changes in our body without us realising it. It influences our subconscious mind positively or negatively to make us feel happy or sad. It directly affects our immune system. In fact in my mind perception is the link that connects our mind to our body.

So let us see how distorted perceptions can affect an individual. Suppose you are looking at your spouse at a distance talking to someone. You come to the wrong conclusion that they are having an affair. Now the moment you make that perception, your subconscious mind will create negative chemicals in your system which will lead to thinking that is essentially negative, which in turn will lead to actions that are fundamentally self-destruct. You will create chaos all round you. Clearly this distorted perception has led the individual to a path of unnecessary self-created misery.

When it comes to personal health many individuals believe that the cure to their illness lies outside them, that is, someone outside them is doing the curing. This in my mind is a false perception.

You see every one of us is born with the healing power within us. This power lies in our immune system and is under subconscious control. It is directly affected by our perceptions.

If you keep a wound clean and protected, it will heal by itself. That is if you provide the right conditions, Mother Nature will heal you. However, if you keep scratching or irritating it, it will never heal. So you see people can heal themselves, if they provide the right conditions for Mother Nature to heal them.

What happens when you go to the doctor? The doctor makes a diagnosis and prescribes the right treatment. We assume the doctor is healing you, but is he? Not really, because what we do as a doctor is prescribe the right treatment and conditions that helps your immune system to heal yourself. If your immune system does not respond, then no doctor in the world can save you. Remember the healing process always takes place within the individual not outside him. It is what you do with yourself 24 hours a day that will heal you. Hence if you provide the right conditions, Mother Nature must heal you.

So you see it is most important for every one of us to understand how our perceptions affect our thinking which in turn can lead us to wrong or right action. If you know you have to power to heal yourself and it lies in your immune system, and it can be boosted with positive perceptions, wouldn't you take steps to straighten out your perceptions on various issues?

Therefore if you are in conflict, stressed out, anxious or depressed, it means you are not in harmony with your subconscious mind and your immune system is at risk. You should not try to keep your feelings to yourself but try to talk to someone who can help you see the problem from another point of view. It is only by straightening out your perceptions that you will be able to find instant relief from your symptoms.

After reading this article your perceptions should be clear about you being the sole person responsible for your own health and that you have the power within to heal yourself. If you think you have got the message but still think someone outside you does the curing, it means that you have not understood what I have written. You are indeed writing your own destiny.

By understanding the three mental properties namely, perception, insight and awareness we have, an individual can acquire self-knowledge that can take him or her beyond any formal education in life. No matter who you are or what you are we all have to come to terms with our inner and outer worlds. This is where my book "The Enchanted Time Traveller – A Book of Self-knowledge and the Subconscious Mind" will be of great help to anyone wishing to discover themselves.

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

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Transcript: AMA President, Dr Michael Gannon, 6PR*, Drive with Oliver Peterson,* Friday 16 March 2018

Subjects: Bupa's changes to no-gap cover policies

OLIVER PETERSON: Now, Bupa's been in the news because it changed some of its health insurance policies. It's got doctors quite angry. To tell us more, the National President of the Australian Medical Association is Dr Michael Gannon, and he joins me on the program. Dr Gannon, good afternoon.

MICHAEL GANNON: Good afternoon, Ollie, how are you?

OLIVER PETERSON: I'm good. First of all, what's Bupa changed? What have they done?

MICHAEL GANNON: Well, what Bupa's done is added to their sad list of exclusions and carve-outs by changing the rules according to whether or not they've got a contract with the hospital you might choose to go to.

So, we know how difficult the health system is to navigate as it is. We know how scared people are when they get sick or their loved ones get sick. We know how hard it is for GPs to keep up with developments in the health system - who's got some specialist skill, who can do this, who can do that?

But Bupa's now added this additional layer of difficulty to patients, expecting patients, expecting GPs to have the literacy to know whether or not a hospital their doctor might choose to look after them in is in contract or out of contract with Bupa. And, if they're not in contract, Bupa's going to retreat all the way back to the scheduled fee, potentially leaving people hundreds of dollars, if not thousands of dollars, out of pocket.

Doctors try very hard on the no-gap schemes - 88, 89 per cent of operations are done under no-gap. But what this means is even if your doctor's willing to no-gap you, Bupa might say: No, that hospital's out of contract, we're hardly paying a cent.

OLIVER PETERSON: And we're talking here, Dr Michael Gannon, about almost three quarters of a million Australians who will be affected by these changes that Bupa's trying to introduce. So, ultimately, Bupa's trying to dictate which hospital you go to, and deciding whether or not if you have a preference to go to one particular hospital – "Sorry, Ollie, all of a sudden you must go to this hospital instead because this is where you're covered".

MICHAEL GANNON: Well this is, again, where they're being totally irresponsible. We know we've got a problem with private health insurance. We know that the annual growth in premiums outstretches wages growth, CPI, et cetera.

In fairness to Minister Greg Hunt, he's trying pretty hard to overcome this. He's sought cooperation from doctors' bodies on out-of-pocket expenses. We don't think we're the problem, but we are working cooperatively with the industry. But the insurers do this, and undo and wreck all sorts of work like that.

If you take the example of a West Australian who might live in Geraldton, if St John's Geraldton falls out of contract with Bupa, what are they saying? That, all of a sudden, you're meant to drive to Perth to get your care? This is totally unfair, it's totally inappropriate. We

know the other insurers are watching what happens with Bupa, but we're not going to put up with it.

OLIVER PETERSON: Yeah, and that's what I was wondering, Dr Gannon, because if Bupa is able to get away with it will the other insurers try it on?

MICHAEL GANNON: Well, I think they will. Now, Bupa is an interesting beast, a multinational company with interests in 190 different countries. Their Australian operations, we believe, are one of their more profitable operations. But they've got interests all around the world and perhaps don't have the same interests that those of us who are stakeholders purely in Australia do.

We've got listed Australian private health insurers like Medibank Private and Nib who are watching what's happening, we've got the mutual health insurers watching what's happening. We know how difficult it is for them to control their costs, but what they do, in biting at patient choice, in biting at the very value proposition of private health insurance, they are helping wreck the value proposition of private health insurance. And I would say to an international company: don't wreck our delicately balanced universal healthcare system that relies both on public and private hospitals.

OLIVER PETERSON: Yeah, and ultimately this is just reducing patient choice, and that is flying in the face of what private health care's meant to be all about, Dr Gannon.

MICHAEL GANNON: Well, that is the fundamental value proposition of private health. We have a fabulous public hospital system in Australia. It was only last week that we launched our Public Hospital Report Card. It shows that, according to a number of key metrics, we're not going anywhere near as well as we would like to. Public hospitals provide the vast majority of emergency care in our country and big ICU beds. But private hospitals do over 70 per cent of the elective surgery, they deliver 30 per cent of the babies, they are brilliant at providing palliative care services, mental health services. And we are saying to this big international company: we are not going to stand by and let you threaten the viability of the Australian health system.

OLIVER PETERSON: All right, Dr Gannon, I will catch up with you soon. Appreciate that, thank you very much.

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17 March 2018

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Bhutan: Small Group Tours

by Cheryl Ryan

Popularly known as the land of the Thunder Dragons, this beautiful country offers some of the most alluring mountain sites. Located amidst Himalayan mountainous landscape, Bhutan is a holiday retreat to serenity. The small group tours in Bhutan cover the stunning valleys of Thimphu, Trongsa, Paro, Gangtey Phobjikha, Punakha, Wangduephodrang, Trashigang and Bumthang. You can experience the real spirit of the Bhutanese in these townships.

A country with extravaganza of natural beauty

Set on the lap of the enchanting Himalayas, Bhutan boasts of some of the exotic and rare flora and fauna. Toorsa Nature Reserve, the Kulong Chhu Wildlife Sanctuary and Phipsoo wildlife Sanctuary are some of the must-visit tourist attractions of the country. This Himalayan nation is truly steeped in majestic mountain vistas and ancient mysticism. Visit the monasteries in the country and the Monastery of Punakha offering breathtaking views. The 13th century Tango Monastery in Bhutan is built over a cave, making it a must-visit attraction.

What have we planned for you?

A complete itinerary includes all the religious, cultural and historical attractions of the country.

- Visit some of the sacred temples and Buddhist monasteries in the Himalaya.

- Explore several cultural attractions in the country including markets, museums and medieval fortresses.

- Hike up to the well known Taktsang Monastery, located around 900 meters above the valley level on a cliff.
- Enjoy the ancient and elaborate carvings and wall paintings in Dzongs and temples.
- Explore the beautiful landscapes of Bhutan from rich valleys to thick forests.
- Village excursions and farmhouse visits to experience the exotic culture of this country up-close.

Be prepared to experience the rich culture and ancient way of life in Bhutan! Join me on a small group Tour March 2018.

www.123Travelconferences.com.au

The Wait for Home Care Packages

Often the decision for seniors to apply for a subsidised home care package is left until circumstances reach a crisis point. By waiting for a crisis to arise, before applying for a home care package, increased stress levels puts patients at risk because the wait to access care can be long.

Approval for a home care package from an ACAT/ACAS team does not mean your patients can immediately access a package. Their name is simply added to the National Queue and they need to wait for a package to become available.

This system has only operated since the end of February 2017 so it is difficult to determine how long the average wait will be, but figures by the Department of Health show expected a wait time of more than six months. Warnings are provided on the myagedcare website that the wait could be more than 12 months.

As the demand for home care increases, the waiting time could lengthen. As at 30 September 2017 there were 101,508[1] ACAT/ACAS approved persons waiting in the queue for either their first home care package or on an interim package. An interim package is the term used for recipients who are receiving a package on a lower level than they are approved for and therefore remain in the queue waiting for their approved level.

What does this mean for your patients?

- ACAT/ACAS assessments should be arranged before reaching crisis critical point
- Patients needing home care support may need to privately fund the full cost of care from their own resources until a subsidised package becomes available – this may need financial advice on planning and managing cashflow needs
- Patients with urgent or severe needs may need to consider moving into residential care if they can find a place more quickly – this should be discussed with the ACAT/ACAS team to ensure the approval is given for both home and residential care
- Patients need to ask the ACAT/ACAS team to also approve respite care as this may provide some support while clients are waiting for a home care package to become available
- Patients may be able to top-up the support that family/friends can provide with services through the Commonwealth Home Support Program.

If you have patients in the National Queue they can gain an estimate of their expected waiting time by logging into their client record using MyGov or by calling the My Aged Care contact centre on 1800 200 422. If you have patients whom are facing the financial minefield of Aged Care, please encourage them to contact me for an obligation free discussion on 07 54379900.

Yours in Aged Care

Sharon Coleman

Accredited Aged Care Specialist / Accountant

[1] Home Care Packages Program Data Report 1 July – 30 September 2017

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NEW LONG-TERM COMMONWEALTH-STATE PUBLIC HOSPITAL FUNDING AGREEMENT NEEDED TO AVERT CRISIS

Launch of AMA Public Hospital Report Card 2018 10.00am, Friday 9 March 2018, AMAQ, Kelvin Grove, Brisbane

AMA President, Dr Michael Gannon, AMA Vice President, Dr Tony Bartone, and AMA Queensland President, Dr Bill Boyd, will tomorrow release the AMA Public Hospital Report Card 2018, an AMA analysis of the performance of Australia's public hospitals.

The AMA Report Card examines public hospital capacity; emergency department waiting and treatment times; and elective surgery waiting and treatment times.

It also provides a State-by- State snapshot of performance.

Dr Gannon said today that the latest AMA Report Card provides clear evidence that all Australian governments – Commonwealth, State, and Territory – need to meet urgently to renegotiate the COAG hospital agreement for 2020-2025.

"The current funding agreement is inadequate to meet current and future health needs.

Without significant new funding for the long term, our public hospitals are doomed to fail to reach performance targets – and patients will suffer," Dr Gannon said.

Launch of AMA Public Hospital Report Card 2018 as follows:

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

- Time: 10.00am
- Date: Friday, 9 March 2018
- Venue: AMA Queensland
- 88 L'Estrange Terrace
- Kelvin Grove
- Brisbane

8 March 2018

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2) Or Emailing to GJS2@internode.on.net

The Burma Railway and Hellfire Pass cont:

http://anzacportal.dva.gov.au/history/conflicts/thaiburma-railway-and-hellfire-pass.pdf

Pat Darling recalls her experience of the plane that came to release them from their prison camp and take them home after the war had ended "Eventually we saw a plane arriving and it landed and the first person off was Dr Harry Windsor ... and he looked at us, we were the only standing people, and he said, 'Where are the Australian nurses?' and we laughed and said, 'We're here!' 'Cause we were dressed as best as we could be ... Matron looked at us. Somebody said, 'But who are you?' and she said, 'I'm the mother of all of you and ever since I've had this position I've wanted to find out where? I was determined to find you.' And she said, 'Where are the rest of you?' and of course there was silence for a moment then a voice, I don't know whose it was, just said, 'They're all dead.'"

Edward 'Weary' Dunlop, Lieutenant-Colonel E.E. 'Weary' Dunlop*, one of 44 Australian doctors on the Thai–Burma railway, was renowned for his untiring efforts to care for the sick. In this audio interview 'Weary' Dunlop recalls his ongoing battle with the Japanese works boss in the camp who would force prisoners to work on the railway although they were very seriously ill. He also describes how these prisoners were subject to abuse and how Dunlop and the prisoners would sometimes succeed in countering this brutality. Well, this was a continuous treadmill in which I used to have to attend the number 1 works' boss of the Japanese, and he would say, 'Tomorrow so many hundred men', and I would say, 'Impossible! We can't turn out this number', and we would argue until 10 o'clock during which time I could usually beat him down a few men. Then I'd have to wait up and see the last of the workforce in — around 2 o'clock in the morning they would come in practically crawling.

So then you've got to make your assessment of how many men would be regarded by the Japanese as 'very fit men' and how many would say 'little sick men, or little byoke men' and this really wasn't official, but I used to have a group of 'little byoke men', and these would be fellows standing shivering with fierce attacks of malaria, pouring dysentery, tropical ulcers, great raw ulcers on their legs or their feet like raw tomatoes, just looking like they had no skin on them, and there they would stand in a dejected group.

But I had still another group: people who we carried out physically and laid on the parade ground, and so these men can't stand up. Sticks would be waved over them and they would be kicked, and if they didn't get to their feet, they might even be given a hammer to crack stones with, it was a relentless business. We had all sorts of tricks. I would instruct people to collapse on their way out of the camp, and we'd rush and carry them to the hospital. We could usually win a few tricks, but you know, that was a sick parade. Stan Arneil was a sergeant in the 2/30th Battalion and a member of F Force when he became a prisoner of the Japanese at Singapore. In this interview he recollects an experience where an officer forced an unconscious, almost dead prisoner to be carried by other prisoners to attend a roll call by which time he was dead.

More about illness and death on the railway. Well, the [cholera] camp broke up. We were to come back, there were around twenty of us left, the cholera had subsided, and we were to come back to the camp, and we had to be counted, as all Japanese or Korean guards, they want everybody counted. We went over there. I was in charge of this little camp. And we lined them up there, and of course we were one short. And the officer said to me 'you're one short'. I said 'It's Dusty Blackadder, sir, I don't think he'll last an hour'. He said 'Well, the guard wants him here'. I said, 'Well look, he'll be dead in an hour, why do we want to bring him over, leave him in peace there, he's on his own, there's not even anybody with him'. He said, 'Go and get him!' So I went back with four men and one of those big bamboo stretchers, which we'd made ourselves, great big unwieldy things, and it was filthy and the mud was waist deep almost with bamboo thorns in the mud, and we had bare feet, of course. I went into see Dusty, and he was unconscious, and we had a look at him, and a little talk about him, and we said, well, he'd be dead, we'd give him half an hour.

Continued Next Month