REDCLIFFE & DISTRICT and BRISBANE LOCAL MEDICAL ASSOCIATION

RDMA & BLMA's Joint Newsletter

Newsletter March 2020

"Value Our Veterans"
http://anzacportal.dva.gov.au/veterans/stories/roy-cornford

See Where We Work & Live P20. Roy Cornford

HTTPS://WWW.FACEBOOK.COM/REDCLIFFEANDDISTRICTMEDICALASSOCIATION/

RDMA President's Report Dr Kimberley Bondeson

Presidents Report - March 2020
Dr Kimberley Bondeson

As I write this, the coronavirus, known as Covid-19 is upon us. It is windy and wet outside, there is a cyclone hanging around the coast of Queensland. But on everyone's mind is this virus. The world around us is changing, as our country gears up to deal with this virus. It has now been called a pandemic, which means that Australia's emergency response plan has been triggered, as well as strengthening Border Force capabilities to stop potentially infected people entering the country. The numbers of confirmed cases of Covid-19 in Australia is still small, to date only have 36 confirmed cases Australia wide. However, by tomorrow, this will increase.

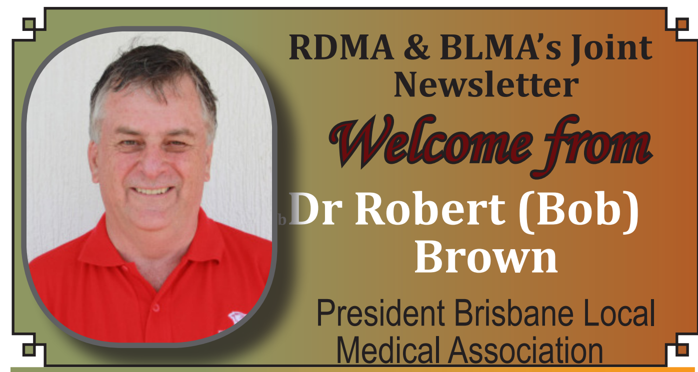
There are travel bans in place, currently a Level 3 Worldwide Travel Warning from the Australian Department of Foreign Affairs and Trade - who now advise all Australians to reconsider their need to travel overseas at this time, regardless of destination, age or health (Smart Travel website, 13th March, 2020). The next stage would be a Level 4 warning - Do Not Travel. This is placing an enormous economic burden on Australia and the world, with a decrease in revenue from tourism and a decrease in trade.

All gatherings of over 500 people have just been cancelled, concerts, sporting games and so forth, to try to stop the spread of the virus. The estimation of the fatality rate is difficult to measure, but appears to be around 3% in Hubei and lower elsewhere. Even 2-3% would have heavy implications for the Australia Health System. Whilst it is difficult to take figures from China and extrapolate to Australia due to the differing age profiles of the population as Australia has an older, more ageing population than China. (The Medical Republic 2 March 2020). It is expected that Australia would see more of an impact. Older people are at greater risk of any infection.

A new telehealth telephone item number has just been released, which will enable doctors to bill the MBS for telephone and telehealth consultations with patients who have tested positive for Covid-19, and other vulnerable/isolated patients. This is a sensible plan, which will mean that my elderly patients do not have to come down to the surgery to sit in a busy waiting room for simple, uncomplicated care, which can be dealt with over the telephone or telehealth.

Italy has just recalled all its retired doctors, and the UK is also talking about recalling their doctors. In the Australian Government pandemic plan, which was in the newspaper, it stated "Doctors and nurses will come out of retirement" (Courier Mail, 7th March 2020). Our very own Dr Geoffrey Hawson, President of Australia Senior Active Doctors (ASADA) is currently working on a plan and a mechanism that will enable those who want to, to come forth and assist the government, when they are called for. He will continue to update with this situation.

Kimberley Bondeson



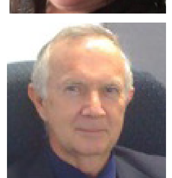
Note: Doctors in Training RDMA Membership is Free
RDMA & BLMA Meeting Dates Page 2.

NORTH LAKES LABORATORY
Partnering with Redcliffe District Medical Association for over 30 years.

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

RDMA Executive Contacts:

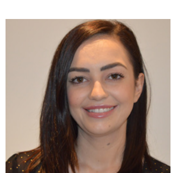
President:
Dr Kimberley Bondeson
Ph: 3284 9777



Vice President & AMAQ Councillor:
Dr Wayne Herdy
Ph: 5491 5666

Secretary:
Dr Geoff Hawson
E: reception@cancersecondopinion.com.au

Treasurer:
Dr Peter Stephenson
Ph: 3886 6889



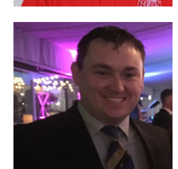
Co-Meetings' Conveners
Ph:3049 4444
Ms Anna Wozniak
M: 0466480315
Email: qml_rdma@qml.com.au

Ph:3049 4444
Ms Amelia Hong
M: 0466480315
Email: qml_rdma@qml.com.au

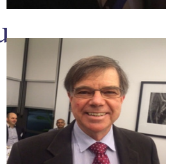
Newsletter Editor Dr Wayne Herdy
Newsletter Publisher. M: 0408 714 984
Email:RDMAnews@gmail.com

Advertising information is on RDMA's website www.redcliffedoctorsmedicalassociation.org/

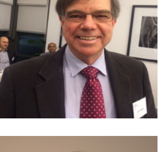
BLMA Executive Contacts:



President:
Dr Robert (Bob) Brown
Ph: 3265 3111
E: drbbrown@bigpond.com



Vice President
Dr Paul Bryan
Ph: 3261 7000
E: paul.bryan@uqconnect.edu.au



Secretary:
Dr Ian Hadwin
Ph: 3359 7879
E: hadmed@powerup.com.au

Treasurer & Meeting Convener
Dr Graham McNally
Ph: 3265 3111
E:gmcnally1@optusnet.com.au

RDMA 2020 MEETING DATES:

For all queries contact Anna Wozniak or Amelia 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	25th
Wednesday	March	25th
Tuesday	April	28th
Wednesday	May	27th
Tuesday	June	30th
Wednesday	July	29th
ANNUAL GENERAL MEETING - AGM		
Tuesday	August	25th
Wednesday	September	30th
Tuesday	October	27th
NETWORKING MEETING		
Friday	November	20th

NEWSLETTER DEADLINE

Advertising & Contribution 15th April 20

Email: RDMANews@gmail.com

W: www.redcliffedoctorsmedicalassociation.org

BLMA 2020 MEETING DATES:

For all queries contact Graham McNally Meeting Convener: Phone: (07) 3265 3111
Email: gmcnally1@optusnet.com.au

W:**https://www.brisbanelma.org/**

CPD Points Attendance Certificate Available
Venue: Riverview Restaurant, Bris
Kingsford Smith Dr & Hunt St in Hamilton
Time: 6.30 pm for 7.00 pm

ANNUAL GENERAL MEETING - AGM		
1	February	11th
2	April	14th
3	June	9th
4	August	11th
5	October	13th
NETWORKING MEETING		
6	November	27th

Next Meeting Date 25th March 2020

RDMA Meeting 25.02.20

Dr Kimberley Bondeson RDMA President Introduced:
Sponsor: Redcliffe & District Local Medical Association.
Speaker Dr Kym Irving, ASADA
Topic : "Update on Australian Senior Active Doctors Association.
Sponsors: Johnson and Johnson
Speaker: Dr Jason Wong,
Topic: Manage Expectations: Follow-up and problems after bar-iatric surgery.
Speaker: Dr Daniel Walker,
Topic: Gastroesphageal Reflux: Who, When & Why to refer for Surgery.

Photos (Left to Right & Down):
1. Sponsors John Bradford, Casey Mayes, Mike DeBruyn, **2.** Geoff Hawson & Kym Irving, **3.** Banyar Than Naing, Yin Mar Myo Aung & Nyo Aing New Members, **4.** New Members Micheal Wing & Meg Spain, **5.** Sean Plumket Med Student, **6.** Thishan Kalouthatage & Sydia Kim **7.** Sophie Gregory & Min Min Win New Member

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 25th of March 2020**
TIME: 7pm for 7:30pm start
VENUE: Regency Room – The Ox, 330 Oxley Avenue, Margate
COST: Financial Members, doctors in training, interns and medical students welcome.

Cancelled

AGENDA:

7:00pm	Arrival & Registration
7:30pm	Be seated – Entrée served Welcome by Dr Kimberley Bondeson – President RDMA Inc
7:35pm	Sponsor: Tilray
7:40pm	Speaker: Dr Ben Jansen Founding Director of Cannabis Doctors Australia and one of Australia's leading prescribers of Medicinal Cannabis. 'Medicinal Cannabis : A Role in General Practice'
8:00pm	Main Meal served (during presentation)
8:20pm	Question Time
8:30pm	Dessert, Tea & Coffee served
8.40pm	General Business

RSVP: By Friday 20th of March 2020
(e) RDMA@qml.com.au or 0466 480 315

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

qml.com.au

INSIDE THIS ISSUE:

P 01: RDMA President's Report & Where We Work and Live

P 02: Date Claimers and Executive Team Contacts

P 03: RDMA's Next Meeting Invite

P 04: Contents and Classifieds

P 05: AMAQ Branch Councillor's Report; North Coast Area, Dr Wayne Herdy

P 06: AMAQ President & CEO Update

P 08: ASADA President's Report; Dr Geoffrey Hawson

P 09: RDMA's Next Month's Meeting Invite

P 10: Skin Rejuvination For You or not For You By Dr Phillip Bushell-Guthrie

P 12: Registration & CPD for Senior Active Doctors: Dr Kym Irving, Associate Member ASADA

P 14: MEDIA: Corona Virus Health Package Welcome but Much More to Do

P 16: Travel Article by Cheryl Ryan.

P 17:Poole Group Update

P 18: MEDIA: AMA DECLARES CORONAVIRUS (COVID-19) A NATIONAL PUBLIC HEALTH EMERGENCY

P 19: Membership Subscription

P 20: Where We Work and Live: Roy Cornford

PUB/MR/1435_V1_Jun17

qml.com.au

Specialists in Private Pathology since the 1920s

Competitive Advertising Rates:

Full page A4: $560.00
Half page A5: $330.00
Qtr page A6: $260.00
Business Card size (new): $70.00
Advertorials: $260.00
Inserts: $260.00

The preferred A5 size is Landscape Format. and A4 size is in Portrait Format.

Please note the following discounts:

- 10% discount for 3 or more placements
- 20% discount for 11 placements (1 year)
- Payments required within 10 working days or discounts will be removed unless a payment plan is outlined at the outset.

CLASSIFIEDS

Classifieds subject to the Editor's discretion.

- No charge to current RDMA members.
- Non-members $55.00

If you would like to advertise in the next month's newsletter please email RDMAnews@gmail.com in one of the preferred formats (either a pdf or jpeg). Advertisers' complimentary articles must be in the same size as adverts. Members Articles are limited to an A4 page with approximately 800 words.

AMAQ BRANCH COUNCILLOR REPORT

Dr Wayne Herdy, North Coast Councillor

HIC Authority Line & COVID 19

I suspect that I use the HIC authority script line more than most. I am very familiar with the system, its limitations, and even the voices of most of the operators (some even recognize my voice too).

It is not a perfect system. Arguably, it is not even a necessary system, but I suppose there has to be some sort of signal sent to prescribers to actually think about what we are prescribing. Anecdotally, I understood that, when the streamlined authority system was introduced for some items, the prescribing patterns nationwide did not change perceptibly. This was cited as evidence that the authority system was superfluous.

It was with some surprise that I noted last week that some operators (whose voices I did not recognize) started asking the questions in a different order from the usual. And the authority number granted started with an M, not the usual Z. And the progress of my telephoned request was MUCH slower than usual. After a few of these, I chatted up the operator and was told that she was not using their usual computer program but the HPOS access that I could have obtained by my own access. After a few of these, and nearly 10 minutes spent on each one, I decided to have another go at using the HPOS direct access myself. After all, it couldn't be slower than the new system. Or could it?

I am unashamedly a techno dinosaur. When I was first given the option of using the HPOS access to Medicare, I quickly decided it was too slow and clunky and decided not to use it at all. This time around, I went through the process with my patient practice manager. By the time I got to where I needed to be, and had learned that I had to be given a message through a different window every time I wanted access, I decided this was still too time-consuming and inconvenient to be a realistic way of talking to a government department. I went back to the ancient process of telephoning for authority scripts. My prevailing thought: if it ain't broke, don't fix it.

Bottom line: in the past several days my telephone authority applications have all been answered by the old system. Maybe even the bureaucrat who decided to use HPOS had recognized that it just wasn't going to work.

CORONAVIRUS COVID-19.
It is impossible to enter any news source today without being bombarded by Corona virus news. Or news about supermarket shortages and toilet-paper wars. Or real news about Corona beer sales plummeting amidst jokes about the guy who ordered a Corona beer and was asked if he wanted a slice of Lyme with that.

How much is hype? How much is helpful? History will tell, because so far I think even the infectious disease experts are scratching their heads. It is indisputably a rapidly-spreading virus, but most patients have trivial illness and the mortality rate is not really all that high. All doctors are plagued by patients and friends trying to sort the wheat from the chaff in this media deluge, and to be truthful I don't think anybody really has a handle on it. "It" being the advice that we can give our patients that will give them meaningful understanding and a legitimate direction to follow.

My take is that containment measures are worthless. At best they might slow the progress of the pandemic, but unless you live on a yacht in mid-Antarctic, they are not going to stop it. Asymptomatic carriers are going to walk among us until they are identified and self-quarantined or hospitalised. Any containment and response strategy is going to last a week, then succumb to the numbers. Depending on which source is correct, maybe 25% or maybe 60-odd% of the world's population will get it. [Those who don't get it in this pandemic might get it in a later pandemic in a few years' time?] Does it really make a difference if everybody gets it in the next two months or whether it is spread over the next eight months? Probably not much.

The biggest positive difference it will make will be that the economic disaster accompanying the pandemic will be over sooner. Employment will return to normal and our share portfolios and superannuation funds will recover sooner. The biggest negative difference that will result from a short-duration high-intensity pandemic is that the health systems will be overwhelmed even more than is inevitably going to happen and maybe more will die. Those that will die who might otherwise have survived will mostly be those who cant get access to a ventilator. When the pandemic really hits us -in the next month or so – our problem will be that the 10-20% who get pneumonia or other severe disease will not have access to a ventilator or even a hospital bed (if there are enough staff to man those beds).

But for 80% of COVID-19 sufferers? A trivial head cold and a fortnight at home watching TV. Let us pray that we and those who we love most are among the 80%.
Wayne Herdy

Dr Dilip Dhupelia,
President AMA Queensland
and
Jane Schmitt,
CEO AMA Queensland

COVID-19 Updates – Staying Connected

As the global COVID-19 outbreak continues to unfold, we recognise the effort all in the medical profession are currently applying to responding to the outbreak and we are here to support members during these challenging times.

The Australian Government has introduced a number of stimulus assistance for businesses that may help your practice through this uncertain time. Eligible small to medium businesses with a turnover of less than $50million that employ staff could receive up to $25,000 available tax free..Our corporate partner, William Buck, has provided the following link to update you on the support provided: https://bit.ly/33wjYsN

The Australian Government has put $2.4billion towards 100 pop-up fever clinics, a $30million advertising campaign and a Medicare item for telehealth consultations. The national triage phone line will therefore be expanded to operate 24/7 to provide advice to patients. The government will establish dedicated Medicare-funded and bulk-billed pathology test for COVID-19 and influenza. Read more here: **https://bit.ly/39TVN9H and here: https://bit.ly/2TWuEhb**

Members involved in key decision-making

We thank AMA Queensland members for providing ongoing feedback on the response to COVID-19 via Queensland Doctors' Community (QDC). All feedback is viewed and acted upon. Your concerns are being collated and escalated to the relevant Departments and Ministers' offices.

In February, AMA Queensland organised a Q&A information session Dr Jeannette Young, Chief Health Officer Queensland Health and we have since been participating in daily teleconferences with the primary care sector and the State Chief Medical Officer to ensure that our members' concerns are acted upon.

We encourage members to continue to raise COVID-19 issues via QDC or by emailing covid19@amaq.com.au over the coming months so that AMA Queensland can continue to advocate on your behalf. We are working with Federal AMA to provide you with advice to best provide

We will continue to provide ongoing updates and frontline advice on COVID-19 to members via Queensland Doctors' Community (QDC), email and our website, as information becomes available.

AMA Queensland is here to support you and your colleagues. Please do not hesitate to call us for support and advice over the coming days and weeks.

Premier's new pharmacy rules place politics above patients

Antibiotics for urinary tract infections will be available over the counter without a prescription in Queensland by the end of the year.

The Queensland Government made the announcement on 8 March – without having any results from its trial of pharmacist prescribing for urinary tract infections (UTIs), which is yet to launch. The three antibiotics to be trialled will be trimethoprim, nitrofurantoin and cephalexin.

AMA Queensland slammed the Palaszczuk Government's move and urged the Government to stop playing politics with women's health in a blatant bid to win votes at this year's State election.

It is irresponsible of the State Government to allow pharmacies to provide antibiotics when the rise of antibiotic-resistant super germs was one of the greatest public health threats of our time.

This move works against all the national strategies that have been put in place in recent years to help control the growing threat of antibiotic-resistant superbugs

Continued Page 7

Continued From Page 6

More than 700,000 people die every year around the world because of infections that are resistant to antibiotics. We need people taking less antibiotics, not more.

The State Queensland's changes disregard national pharmacy considerations underway by the Australian Health Protection Principal Committee (AHPCC) and a recommendation of the Therapeutic Goods Administrations Independent Advisory Committee on Scheduling.

No other state or territory has taken this action. It's hard to view the Premier's announcement – made on International Women's Day – as anything but a blatant grab for votes at the expense of women's health.

These changes are more about bowing to pressure for profits from the pharmacy sector than improving women's health care.

GPs are right to be concerned. We must never place politics ahead of public health.

AMA Queensland Obesity Awareness Week 2020

In March, AMA Queensland staged its inaugural Obesity Awareness Week (OAW), a grassroots public awareness campaign aimed at encouraging obese and overweight people to take small steps towards a healthier future and to contact their GP for help in adopting healthier habits. Run from 2-6 March, in partnership with Screen-Free Week, the campaign was timed to coincide with World Obesity Day on 4 March and challenged Queenslanders to make one small change to their diet or exercise regime each day of the week.

This ranged from moving more to drinking less sugary beverages, or reducing the amount of screen time. AMA Queensland was delighted to provide AMA Federal and all the other State and Territory

AMAs marketing resources, templates and social media collateral to raise awareness in their own communities and participate in the campaign.

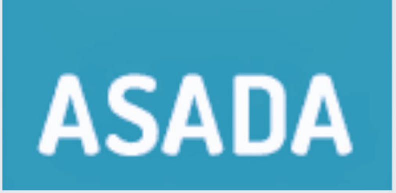
GPs received information kits to assist in discussing obesity-related health issues with patients and to seek their participation in our efforts to help curb the scourge of obesity at the grassroots level.

Response to OAW has been overwhelmingly positive. A short survey of GPs on their obese and overweight patients yielded insights that made newsworthy content for numerous media outlets, including several Queensland television and radio stations, almost every metropolitan daily newspaper in the country as well as The Australian.

Nominated AMA Queensland media spokespeople across the state ensured the OAW campaign was covered in local and regional news outlets and we received emails and letters of support from a number of Queensland Health and Education Queensland leaders.

While AMA Queensland took the lead on OAW, we look forward to the campaign becoming a bigger, even more successful annual national initiative in coming years.

Dr Dilip Dhupelia, President AMA Queensland **Jane Schmitt, CEO AMA Queensland**



AUSTRALIAN SENIOR ACTIVE DOCTORS ASSOCIATION

Australian Senior Active Doctors Association: Response to Government calls for retired and senior doctors to assist with public health emergencies

Currently there are two groups of doctors who could contribute their services. Retired doctors and senior active doctors.

Once the government puts in place mechanisms to enable retired doctors to practice, they could volunteer their services in a call up.

Many senior active doctors who are currently registered to practice are transitioning towards retirement and wish to continue contributing to the healthcare of Queenslanders. The government could provide for a step down or occasional practice registration category to keep these doctors in the system and available to practice in the community as needed.

In the past such a category existed and could be expanded and reinstated for senior active doctors. The government could establish a similar category for retired doctors.

ASADA strongly believes that retired and senior active doctors are an underutilized asset in advancing the health of Queenslanders and all Australians and welcomes discussion around how these doctors could contribute their vast experience and expertise if they wish to volunteer.

Proposed New Model of Registration

1. **Registration category –**
   a. Limited Registration -Public Interest – Senior Active Doctor
   b. Retired doctors who volunteer for call up in emergency allowed to register in category a and exempted from 4 (CPD)
2. **Register** - doctor would remain on the register of medical practitioners
3. **Practice** - Referral, order, prescribe, teaching, practice within their scope of practice
4. **Reduced CPD** –10 hours related to practice with emphasis on skills and education
5. **Remuneration** – allowed depending on requirements of practice
6. **Insurance –** indemnity required at lower rate, government indemnity for government-directed practice

Monthly Meeting

Redcliffe & District Medical Association Inc.

Cancelled

DATE: **Tuesday 28th of April 2020**

TIME: 7pm for 7:30pm start

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

COST: Financial Members, doctors in training, interns and medical students welcome.

AGENDA:

7:00pm	Arrival & Registration
7:30pm	Be seated – Entrée served Welcome by Dr Kimberley Bondeson – President RDMA Inc
7:35pm	Sponsors: iNova Pharmaceuticals
7:40pm	Speakers: Dr Rakesh Malhotra - Endocrinologist 'Managing Obesity in General Practice - An Interactive Case Series Presentation'
8:00pm	Main Meal served (during presentation)
8:20pm	Question Time
8:40pm	General Business and Dessert, Tea & Coffee served

RSVP: By Friday 24th April 2020
(e) RDMA@qml.com.au or 0466 480 315

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

SKIN REJUVENATION for YOU or not for YOU?

By Dr Phillip Bushell-Guthrie
Portside Plastic and Cosmetic

If you are over 20 years of age and live in Australia the chances are that you will have some skin damage on your face neck and probably hands as well. If it is bad it will be apparent. If it is not too bad you may not be aware of it but it will slowly but surely get worse damaging your skin cells and becoming apparent in the years ahead. Often people grow their first skin cancer around 40 years of age.

There is no argument about skin care which includes sun protection. It slows or stops the formation of skin cancers importantly malignant melanomas. This prevents you ending up with scars even if they are good or those horrible white freeze marks on your face. It also preserves the quality of your skin especially the elastin and this keeps you looking better. It is necessary to remember to slip slop slap and shade especially if you are of fair complexion.

When it comes to skin rejuvenation for appearance a lot of people are ambivalent about it. It may be considered too much trouble too costly or just unnecessary but none of the above are necessarily true. Considering that the underpinning basis for rejuvenation is preventative skin care it will help to reduce the burden of skin cancers. It is just serendipity that the treatment that makes your skin look better also helps to reduce sun damage and therefore presumably sun cancer although I am not aware of any hard data on that.

So apart from prevention what can be done? There are creams that can be used and if they are used consistently they will make a noticeable difference starting within two months. It is preferable to start early say in your twenties or early thirties because it is easier to hold onto what you have rather than to try to retrieve it later.

There are four different creams that one should be using for rejuvenation if you are serious about it. At least three of these should be used on a regular basis. It is no use using one cream now and then and complaining about it not working. As always compliance is very important.

The first cream is the fat soluble form of vitamin C in an ester with palmitic acid. This keeps it stable but when it is placed on the skin it breaks down to ascorbic acid. There are cell receptors for ascorbic acid and these appear to boost cell function. Also Vitamin C is part of the production line for the synthesis of collagen. Vitamin C is also an antioxidant and anti-inflammatory which has some role to play also. It is applied in the morning. It rapidly sinks into the skin leaving almost no residue.

The second cream is vitamin A or retinoic acid. There are receptors on the cell surfaces for vitamin A and once again it acts to improve cell function probably by boosting the function of the fibroblasts via mRNA in the cell. These cells produce collagen elastin and hyaluronic acid which are the vital components of our skin. Vitamin A is usually applied at night to reduce the photo sensitising effect that it can have.

There is evidence from scientific trials that shows improvement in skin quality from the use of these two agents. As far as I am aware there are no other properly designed trials to show benefit for any other agents. However there is anecdotal evidence that some other agents are of value also.
The third agent is a peptide cream that can be used with or alternated with the vitamin A cream. This agent contains short peptide chains. The aim is to signal to the fibroblast that it needs to increase its production and presumably to other skin cells as well improving function all around. It can be applied alternately with vitamin A in the evening.

We know that cells signal or talk to each other by releasing these short chain peptides as messengers and that they attach to

SKIN REJUVENATION for YOU or not for YOU?

By Dr Phillip Bushell-Guthrie
Portside Plastic and Cosmetic

specific receptors on the cell surface but the trick is of course to get the right peptide combination to give the correct message. As far as I am aware there is no published data on this for cosmetic purposes. It would appear to be all commercial in confidence which is probably just as well because if hard data was available these agents may be classified as S4. That may happen one day. All I can say at present is that they do appear to be of benefit but at this stage it is hit and miss.

The last agent is a good quality sunscreen which these days usually start at SPF 30 and go to about SPF 50+. Now there is not much difference in protection between the 30 and the 50 SPF ratings. More important is to reapply it after a few hours if you are out and about in the sun or you are swimming. The sunscreen is placed on after the vitamin C and makeup can be placed over the sunscreen if it is a good quality one that has been applied evenly. Some facial sunscreens have a tint in them that can soften the appearance of sun damage as well. Sunscreens also act as moisturisers and need to be applied nearly every day.

In this article I have touched upon the home care aspect of non-surgical skin rejuvenation. In the next article I shall talk about rooms procedures that are minimally invasive and then finally the surgical option for rejuvenation. It is a continuing spectrum that you need to draw from as needed.

Dr Phillip Bushell-Guthrie

Portside Cosmetic and Plastic

SPORTS & SPINAL INTRODUCING OCCUPATIONAL THERAPY

Our Occupational Therapists;

- Deliver quality care with the ultimate rehabilitation solutions.
- Are part of a qualified and experienced team providing professional rehabilitation services.
- Will help our clients maintain their independence at home and within the community through in-home rehabilitative care.

We can assist with:

Home Assesment

Equipment Prescription

Home Modifications

Occupational Therapy at Sports and Spinal covers a wide region from the Sunshine Coast to Brisbane and the Gold Coast. Our mobile home visiting service provides services to NDIS clients, Veterans (DVA) and Seniors including Home Assist

total rehab solutions

For more information about our Occupational Therapy Services contact us via email or phone:
admin@totalrehabsolutions.com.au
1300 685 046

Registration & CPD for Senior Active Doctors: Possible models from Australia & around the Globe

Kym Irving PhD, Assoc Member ASADA

This article provides an overview of the history and models of registration for senior active and retired doctors in Australia as well as food for thought on what a possible model might entail.

Prior to the establishment of the NRAS (National Registration and Accreditation System) and the inception of AHPRA in 2009-10, a category of limited registration existed under the Qld State Medical Board system that enabled doctors who no longer fulfilled the requirements for general or specialist registration to maintain their ability to refer, order and prescribe (limited). With AHPRA that ability ceased except for a small cohort of doctors (Qld, NSW, Tas, and ACT) who continued their registration for a limited time under the LRPI-OP (Limited Registration Public Interest – Occasional Practice) provisions. LRPI-OP was closed to new registrants and abolished on 1 July 2013 under AHPRA. Registration then became full or nothing.

ASADA came into existence around this time and advocated for continuation of LRPI-OP. There was widespread support for continuation of the category (e.g., RACGP, ASA, ASOS, ASOHNS, AOA, AAS, ASCTS,) but little support came from Federal AMA and the medical boards. A 2011 Senate Inquiry Committee recommended that the National Law be amended to provide further practicing classifications to encompass doctors who practice in a limited manner. At the time, the President of the RACGP said: “There was absolutely no evidence that the college could uncover, despite repeated requests, that there were any dangers, or safety or other related issues, with these very, very limited rights for retired doctors …. So it was not an evidence based decision.”

As LRPI-OP was being abolished for doctors, state law societies were encouraging retired lawyers to undertake pro bono work in the community by issuing free volunteer practising certificates. By 2015, free practising certificates were available in five jurisdictions including Queensland after appropriate legislative changes were enacted.

There are now strong winds of change in present day health care that provide both challenges and opportunities for all doctors including senior active doctors. Recent years have seen rapid expansion of the scope of practice for allied health professionals in Qld. Since 2011 changes to state legislation have been enacted to extend scope of practice of a range of health professions in order to: “improve access to services, reduce waiting times in the emergency department and for outpatient specialist and surgical appointments, and improve patient flow”. This includes MRI referral (audiologists); pathology referral and interpretation (physiotherapists, podiatrists, dietitians); prescribing rights (physiotherapists, speech pathologists and podiatrists); and for pharmacists: authority to vaccinate (influenza, measles mumps), prescribe antibiotics for urinary tract infections, and provide repeat prescriptions for the oral contraceptive pill.

At a national level there has been expansion of scope of practice for nurse practitioners who can:

- Diagnose and treat a wide range of health conditions
- Design and implement therapeutic regimens
- Initiate referrals to other health professionals
- Order and interpret pathology and radiology tests
- Prescribe medications, and deprescribe, and access the PBS
- Provide patient rebates for some services through Medicare

ASADA aims to: maintain, advance and promote the active contribution of Senior Active Doctors to Australian medicine and Australian healthcare and the maintenance of clinical privileges within a framework of evidence based public regulation of Australian medical practice; develop and promote policies that maximise the contribution of Australian Senior Active Doctors to Australian healthcare and allow for graded transition of roles for senior years of practice at the discretion of the senior doctor; and to research, develop, establish and promote policies that will mobilise the contribution of Australian Senior Active Doctors to Australian healthcare.

ASADA is currently working on developing a model of registration for senior doctors and is seeking your ideas on what this model should look like. A 2017 RDMA survey (see February 2018 RDMA Newsletter) found that a large majority of respondents (88%) believed that a step down registration category should be considered to enable doctors to refer, order and prescribe with an appropriate level of CPD: We need to continue to work towards a more sensible plan, which allows retired doctors to continue to contribute to the profession. It’s noteworthy that a majority of currently registered doctors wish to continue contributing to their communities and profession as they transition to retirement but are frustrated at how this can be achieved under the current system of registration.

Models from around the globe

In Denmark, permission to practice independently as a medical doctor expires at 75, however the right to use the professional title (medical doctor/specialist) is maintained and medical doctors may continue to prescribe medicine for their own use as well as for the use of close relatives if pro bono.

Canada and the United States have not gone down the path of national regulation of registration as in Australia. They have maintained a system of doctor registration administered by state/provincial medical authorities. These authorities determine the classifications of registration, and these can vary between states or provinces depending on regional needs. In British Columbia, semi-retired physicians/surgeons who no longer have an office practice can apply to

Kym Irving PhD, Assoc Member ASADA

undertake surgical assists only. If eligible, they are exempt from meeting the CPD/CME requirements, however they are required to surrender their privileges, including prescriptions, and peri-operative orders.

In the United States, "upon recommendation from the Council on Medical Education, the American Medical Association developed a licensure relief model for retired physicians working in free clinics. The model recommends that states adopt legislation which would exempt retired physicians practicing in free clinics from the licensing board registration fee." (https://www.ama-assn.org/member-groups-sections/senior-physicians/about-senior-physicians-section-sps). For example, in Florida, a doctor holding an active license to practice medicine in the state may convert that license to a limited license for the purpose of providing volunteer, uncompensated care for low-income Floridians through government and eligible non-profit agencies.

Many states now have provisions for retired doctors:

- to practice in a voluntary capacity on a pro bono basis;
- offering services through charities and agencies
- to benefit indigent and uninsured patients
- and during times of emergency.
- Registration fees can be exempted and required continuing education hours are often reduced.

(https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/licensing-provisions-liability-laws-sr-volunteer-physicians.pdf)

The American Medical Association has a long-standing Senior Physicians Section. All AMA members 65 years and over have automatic membership of the section. Coming up to their latest annual meeting they have called for member resolutions in 5 key areas:

1. Practice patterns and transitioning out of practice. Senior physicians should stay in practice as long as they have the desire and competency to do so, in order to care for an expanding patient population. How can senior physicians be an ongoing resource, thereby using their talents and experience?
2. Senior physicians' roles in supplementing or filling gaps in community health needs. How can senior physicians impact health concerns or the delivery of health services for the medically underserved or those suffering chronic diseases?
3. Overcoming barriers to adopting and implementing technology. What kind of improvements can be made to address record keeping, administrative processes, or care coordination to help physicians as they age?
4. Roles in medical education. How can senior physicians play a greater role in the medical education process? Are there volunteer opportunities such as preceptors, medical student or undergraduate advisors?
5. Licensure for "partial" or reduced scope of practice. How can limited license status be developed for senior physicians when they are no longer in full-time practice?

The UK national system is similar to that in Australia – full registration or nothing - but watch this space. In recent years, a Retired Members Committee has been established within the British Medical Association (BMA) and at the 2019 Annual Representative Meeting (cf AMA Nat Conf) of the Representative Body (cf AMA Delegates) the committee put forward the following motion which was unanimously carried: "That this meeting calls on the General Medical Council to change its retiral, revalidation and re-entry processes in order to retain senior members of the profession to contribute to clinical services, teaching and research. "

ASADA strongly believes that senior active doctors are an underutilised asset in advancing the health of Queenslanders, particularly in this time of rapid expansion of scope of practice for other health professionals. They could:

- provide a valuable resource in national emergencies, e.g., bushfires, terrorism and pandemics,
- assist in vaccination of the population,
- monitor chronic conditions, e.g., hypertension, diabetes through pharmacies or other agencies,
- assist in under staffed rural practices,
- provide pro bono/volunteer services,
- and much, much more.

Who would an occasional practice/senior active doctor registration category apply to? There is no clear age basis for the transition into occasional practice. Doctors over age 55 may be considered senior in the sense of having achieved a high level of medical expertise and practice, however life events can occur at any time which preclude doctors from continuing in their practices, and transitions into semi-retirement can occur at any stage of a doctor's career. This includes doctors who for whatever reason (e.g., childrearing, parent care, illness) have chosen to reduce their practice but for whom maintaining full registration is extremely difficult given current recency of practice and CPD requirements. As Pesce (AMA President, 2011) stated: There are many reasons why doctors of any age, at any time in their lives, may choose to undertake a limited scope of practice. The challenge for the profession now is to be clear about what those limited scopes of practice might be, and what the appropriate registration requirements should be in terms of continuing professional development and medical indemnity insurance…

1. What model of registration and CPD do you want as a senior active doctor should you choose to be one?
2. Refer, order, prescribe? Or more? Paid? Unpaid?
3. Provide services where? Government and non-profit agencies? Provide services to whom? CPD?

Let ASADA/RDMA know - Send your thoughts and ideas to the RDMA or ASADA executive: ASADA_secretary@outlook.com

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Australian Medical Association Limited
ABN 37 008 426 793

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

AMA

CORONAVIRUS HEALTH PACKAGE WELCOME BUT MUCH MORE TO DO

AMA President, Dr Tony Bartone, said today that the AMA welcomes the Government's Covid-19 health package - especially the roll-out of new Medicare telehealth items and respiratory clinics.

Dr Bartone said this is a really good start but there is much more to do to reduce the movement and spread of the virus.

Dr Bartone said the AMA has been calling for the telehealth items since the bushfire crisis to help doctors and patients in emergency situations.

"The new telehealth items will help doctors to safely assess patients who may have contracted coronavirus," Dr Bartone said.

"GPs will be able to assess people who are concerned that they may have come into contact with Covid-19 and help contain the virus, particularly as most people will simply need to self-isolate while recovering from it.

"This initiative will support and protect patients who are more vulnerable to the impact of the virus by keeping them away from areas where they might be exposed to the virus, and help to minimise the risks of transmission.

"With growing concerns about the adequacy of the supply of Personal Protective Equipment (PPE), it would also reduce demand on valuable PPE.

"The AMA is also seeking more information about the extent to which these new telehealth items will be available to all members of the medical profession at the forefront of guarding against coronavirus.

"Broad access to telehealth means that we can engage doctors who may not be able to be involved in assessing Covid-19 patients because of practice infrastructure issues and underlying health restrictions, including doctors who themselves may have to self-isolate for 14 days.

"By treating the vast majority of 'well' patients with Covid-19 at home, we are significantly reducing the spread of the disease in the community.

"Most patients will present with little or no symptoms. These measures are all about having our health system prepared and properly resourced to stop the spread of the virus."

Dr Bartone said the AMA will work with Primary Health Networks (PHNs) and other groups to identify the most appropriate properly resourced sites for the 100 new 'pop-up respiratory' fever clinics announced by the Government.

"These will need to be located in larger general practices that have the space and infrastructure to cordon off a separate clinic area to allow normal everyday GP work to be conducted without interruption.

CLASSIFIEDS remain FREE for current members & a maximum of 3 placements & not used as advertisements. To place a classified please email: RDMAnews@gmail.com with the details.

DISCLAIMER: Views expressed by the authors or articles in the RDMA Newsletter are not necessarily those of the Association. RDMA Inc accepts no responsibility for errors, omissions or inaccuracies contained therein or for the consequences of any actions tas a result of anything publications.

Australian Medical Association Limited
ABN 37 008 426 793

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

AMA

CORONAVIRUS HEALTH PACKAGE WELCOME BUT MUCH MORE TO DO

"The fever clinics should be spread out across population areas, have multiple exits, and be near public hospitals to allow easy transport of patients with severe Covid-19 symptoms.

"We need to get these clinics identified and up and running as soon as possible," Dr Bartone said.

Dr Bartone said it is vital that the Government's $30 million national communications campaign gets clear and comprehensive public health messages and information to the general public and frontline health workers as a matter of urgency.

"There is a lot of information flowing from the Federal and State and Territory Governments, and from Chief Medical Officers and Chief Health Officers and Health Departments, but the AMA is hearing that the messaging has been inconsistent, and sometimes conflicting.

"Local GPs in suburbs and towns are telling us that the flow of quality information is sometimes poor, and the supply of protective equipment is inadequate in places.

"We need to see clear and instructional education and information material, in many languages, at every airport, railway station, bus stop and station, doctor's surgery, shopping centre, office blocks, schools, post offices, everywhere where people gather.

"Posters, signs, and ads must be splashed across print, radio, television, cinemas, digital channels, and social media very soon.

"Covid-19 is a national emergency, and we must all respond accordingly. Education about how to avoid contracting this deadly virus is crucial to stop its spread," Dr Bartone said.

Dr Bartone said that the AMA is very concerned about the serious impact Covid-19 will have on the aged care sector. The AMA is confident there will be further Government announcements to cover this sector in coming days.

---

11 March 2020

CONTACT: John Flannery 02 6270 5477 / 0419 494 761
Maria Hawthorne 02 6270 5478 / 0427 209 753

Follow the AMA Media on Twitter: http://twitter.com/ama_media
Follow the AMA President on Twitter: http://twitter.com/amapresident
Follow *Australian Medicine* on Twitter: https://twitter.com/amaausmed
Like the AMA on Facebook https://www.facebook.com/AustralianMedicalAssociation

CLASSIFIEDS remain FREE for current members & a maximum of 3 placements & not used as advertisements. To place a classified please email: RDMAnews@gmail.com with the details.

DISCLAIMER: Views expressed by the authors or articles in the RDMA Newsletter are not necessarily those of the Association. RDMA Inc accepts no responsibility for errors, omissions or inaccuracies contained therein or for the consequences of any actions tas a result of anything publications.

ARMENIA
by Cheryl Ryan

Armenia located in Eurasia known for its incalculable monasteries and the oldest winery in the world is a country that will leave you dumbstruck with its scenic landscapes and adventurous mountainous terrains. The magnificent snow-capped Mount Ararat – Armenia's national symbol and also a sacred mountain, which is also the resting place of Noah's Ark as per Christianity, is the pride of Armenia.

Armenian Cuisine
Conventional Armenian cuisine is a rich combination of vegetables, meats, eggplant and a variety of flatbreads. You must also try the Armenian fruits and vegetables from the local markets.

Some must-try preparations are Dolma (grape leaves stuffed with minced meat, rice and herbs); Khorovats (barbecued pork, lamb, beef and vegetables); Borscht (a red soup made with beetroot and sour cream) and Manti (meat dumplings). Matsun (traditional Armenian yogurt) and Tan (a refreshing yogurt drink) is suited to the hot climate. Armenian dessert Baklava made with layers of phyllo pastry and nuts; and the sweet sausage-like Sudjukh is to die for!

What Have We Planned For You
• Visit the City of Cafes and the capital of Armenia – Yerevan. See the Blue Mosque – the only mosque in the whole country – the grand Republic Square and the Armenian Genocide Memorial, or take a walk through the Hordon Gorge and shop at the Vernissage flea market.

• Take a 30 minute drive from Yerevan to Echmiadzin which is of historical importance.

Armenia was one of the first countries to declare Christianity as its official religion and to commemorate this, a cathedral was erected here. Home to several churches and a UNESCO Heritage Site this city is widely visited.

• Explore few of the countless monasteries across the country – Tatev Monastery, Khor Virap, Geghard Monastery and Noravank Monastery being the most notable.

• Armenia is peppered with natural wonders and scenic beauty. Don't miss the picturesque Lake Sevan along with its many water sports and finger-licking fish dinners.

• Explore more natural wonders like the peaceful Dilijan National Park and the gorgeous Debed Canyon or go trekking on the Azdahak – a volcano and the highest point of the Gegham Mountains.

• Be captivated by the Temple of Garni which is the central shrine for Armenian Neopaganism and was built in 1st century A.D. is a sought after tourist spot and proof of Armenia's multi-religious fabric.

A mélange of historic traditions interlaced with the modern world, Armenia is waiting to be explored!

www.123Travelconferences.com.au

123 TRAVEL CONFERNCE

Why is “Wealth Process and Structure” important?

Whether we like it or not, it us versus the tax department or versus potential litigation. It lies with ourselves to ensure we have the best “Wealth Processes and Structures” in place.

As a firm, we have experienced generational wealth being transferred down the family blood line. As a result we have seen firsthand how important it is to have all the family’s “financial ducks in a row”.

There are plenty of investment structures to consider such as family trusts, unit trusts, companies, self-managed super funds, partnerships and investing in your own name. Over the years we have seen complex family trust deeds that work well whilst the family is younger and can distribute funds to beneficiaries however, with age they can become restrictive and begin to hinder a family’s options.

We find it really important to ensure investment structures are simple and adaptable so they fit into the family’s current financial position and the stage the family is in their life cycle. A good example is where we have had adaptable strategies in place to help our clients pay for parents/grandparents with aged care and assisted home living expenses, whilst maximising Government assistance.

The horror stories we have witnessed where control of investments and structures are held outside the family can create issues when capital is required when family member’s health changes rapidly.

Having the options and liquidity in place to help assist the family at times of need is where we feel it is so important. Being prepared delivers the family the best options to look after the most important people in their lives.

As we are on the topic of protecting family assets Income Protection is an essential tool in protecting your continued ability to generate income. Major changes to Income Protection arose from the Royal Commission and these take effect from 31 March 2020. We feel it necessary to mention the these changes below as the time to act is now. If you have income protection please read on.

From 31 March 2020 Agreed Value income protection policies will no longer be available for new policies. This is particularly relevant for self-employed persons where annual income may fluctuate, especially in the medical industry.

By July 2021, insurers are expected to no longer offer some other benefits, with the two biggest changes being:

- Policies will no longer be “guaranteed renewable”. As a result, every five years the insurer can revise the terms and conditions of a policy and re-assess the insured’s income and occupation position. Current policies lock the insurer into the terms and conditions from policy commencement and these terms and conditions cannot be made worse, only improved for the benefit of the insured, not the family that needs the cover. This means that:
  - If you changed occupation, income decreased, or not working at that moment and the policy was reviewed at the five-year interval, you could find the cost of the cover increasing or the insurer no longer offering you cover;
  - At the five-year interval, the insurer may also decide to change the terms and conditions of your policy.
- Policies with long term benefit periods (typically “to age 65”) should have controls in place to limit the ongoing claim, such as having a stricter disability definition for longer benefit periods. This means that they are bringing in additional ‘tier’ criteria to meet to remain on claim. In other words, if you can work in other occupations insures may not pay.

Therefore, locking in your income protection contracts before this date is highly recommended.

Whilst health is the wealth, having all your financial ducks in a row will help build options for your family’s future. If you would like to discuss this article further please give me a call on 07 5437 9900.

Article Written by Kirk Jarrott – Partner Poole & Partners Investment Services Pty Ltd

Australian Medical Association Limited
42 Macquarie Street, Barton ACT 2600:
PO Box 6090, Kingston ACT 2604
ABN 37 008 426 793
T: (02) 6270 5400 F (02) 6270 5499
Website : http://www.ama.com.au/

AMA DECLARES CORONAVIRUS (COVID-19) A NATIONAL PUBLIC HEALTH EMERGENCY

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

AMA President, Dr Tony Bartone, said today that the AMA Federal Council has declared the coronavirus outbreak a national public health emergency.

Dr Bartone said the AMA calls on all Australian governments to act urgently on all public health measures to prevent community transmission of Covid-19.

“The Covid-19 outbreak is a national public health emergency,” Dr Bartone said.

“We need to get ahead of the curve – and this must start with the immediate banning of mass gatherings and ensuring that frontline medical and health workers are provided with the best possible information and equipment to protect the health of Australians.

“The Government’s public health advertising campaign must provide consistent and clear messages to allow Australians to guard against transmission and to go about their daily lives,” Dr Bartone said.

The AMA Federal Council, meeting in Canberra today, made the following declaration:

1. Representing Australia’s Doctors and their patients, the AMA acknowledges our public health authorities have been acting along lines of other Western Nations, but we are concerned Australia has not moved fast enough to contain community transmission by taking the type of significant community control measures like those that have stalled community transmission in Singapore and Hong Kong.
2. The AMA has for some time called for banning of large public gatherings. This is an overdue need to protect and ensure the health of the Australian community.

Mass gathering bans should have been established earlier.

3. The AMA also today again called for all Doctors, be they GPs or Medical Specialists, to be able to use telehealth for any regular consultations with their patients, not just those patients needing testing or care for COVID-19.

Today’s meeting of the AMA Federal Council is the last formal large group gathering of the Federal AMA until further notice.

13 March 2020

CONTACT:
John Flannery 02 6270 5477 / 0419 494 761
Maria Hawthorne 02 6270 5478 / 0427 209 753

Follow the AMA Media on Twitter: http://twitter.com/ama_media

Follow the AMA President on Twitter: http://twitter.com/amapresident

Follow Australian Medicine on Twitter: https://twitter.com/amaausmed

Like the AMA on Facebook https://www.facebook.com/AustralianMedicalAssociation

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION INC
MEMBERSHIP SUBSCRIPTION BENEFITS

ABN: 88 637 858 491

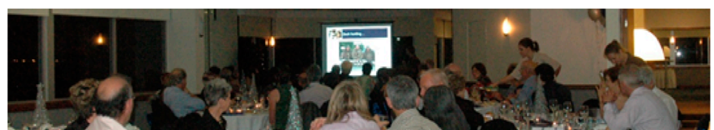
Notice to New and Past Members

RDMA END OF YEAR NETWORKING FUNCTIONS

Don't waste time! Join now!

CPD Points Certificate Available

Get Your Membership Benefits! Socialise! Broaden your Knowledge!



Dear Doctors

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

This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and speakers are most welcome. Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost.

RDMA SUBSCRIPTION FORM - INTERNET PAYMENT PREFERRED

Treasurer Dr Peter Stephenson Email; GJS2@internode.on.net

ABN 88 637 858 491

1. One Member (July to June: $120.00; Oct to June: $90.00; Jan to June; $60.00; April - June: $30.00)
2. Two Family Members ($20.00 Discount each) ($200 pro rata) (Please include each person's details)
3. Doctors in Training and Retired Doctors: FREE

1. Dr --

(First Name) *(Surname)*

Email Address: --

2. Dr --

(First Name) *(Surname)*

Email Address: --

Practice Address: ---------------------------- *Postcode:* ------------

Phone: ---------------------------- *Fax:* ----------------------------

CBA BANK DETAILS: Redcliffe & District Medical Assoc Inc: BSB 064 122 AC: 0090 2422

1. PREFERRED PAYMENT METHOD: INTERNET BANKING

2. PAYMENT BY DEPOSIT SLIP: INCLUDE your name: ie: Dr F Bloggs, RDMA A/C and Date

3. ENCLOSED PAYMENT: (Subscription Form on website, type directly into it and email)

i) Complete Form and Return: C/- QML or RDMA at PO Box 223 Redcliffe 4020

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

" Value Our Veterans"

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

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.

POWs rescued by Pampanito

The submarine surfaced. The name of the submarine was the [USS] Growler and it attacked the destroyer. Luckily they fired two torpedoes at it head-on and one of the torpedoes hit it. That caused a fire and a lot of damage to start with, and then the second torpedo they fired blew it up. Well, I was on deck when the first torpedo hit it and there was only a bright flash from that. And the Japanese guard near us says: "Oh, a fire on the island." And when the next torpedo hit that destroyer and it blew up he never said anything. But the prisoners near us said: "Hello, the island's blew up".

Then the panic started. That destroyer – that submarine pulled out of the chase then. As it surfaced to dodge depth charges they lost track of the convoy and the other three submarines attacked the convoy and they sank a transport ship near us. I was on deck and we saw all this. Then they sank a transport ship on the other side of us. And then there was an oil tanker about 500 metres from us and they sank it. But before it sank you could see the Japanese sailors trying to run along the deck in the burning oil and [then] it exploded. Next they sunk an oil tanker on the other side of us.

It was then we copped one. Luckily the first torpedo hit the hull on the forward part of the ship which was full of rubber and that took most of the shock, but the big splash of water that came up over the deck washed us and roughed us all up against the deck cabins and things like that. For the people down in the hull, the water poured down on top of them and of course they were screaming and panicking.

The second torpedo was only about 10 to 12 seconds later than that and it hit the engine room. And when it hit the engine room the ship sort of just dropped about 10 feet. And it sort of laid over on its side a bit. But then all the Japanese were getting into the lifeboats and getting away and we were tossing rafts over. So many men were getting on each raft. And when we got down to the rafts there was only one raft left and there were eight of us. We said 'Well, we'll have a drink of water first. So we went and got a belly full of water and we tossed that raft over and we all jumped in the water and got on it.

We'd only got about 100 metres away from the ship and another Japanese naval boat came back flashing lights everywhere, but then it got torpedoed. And the concussion of those torpedoes hitting the ship affected our stomachs and I got as sick as anything and lost all the water I drank. Well then we got on the raft, eight of us, and we pushed our way away from the ship a bit, and all the rafts kept coming in close together and we were all pretty close together.

Continued next month.