RDMA
RDMA & NLMA's Joint Newsletter
Newsletter
OCTOBER 2017

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 October, and a wet October it is. We have not had a proper wet season for many years, and it appears we have one this year, albeit a bit early. There is minor flooding around Bundaberg and Rockhampton regions so far.

I attended the recent AMAQ Conference in Rome – what a fantastic ancient city, full of incredible history. We visited the famous city of Pompeii, St Peter's Basilica and the famous Trevi Fountain. The city of Rome has around 3 million residents, and walking down the streets of Rome, you can see the parts of ancient Rome, incorporated into modern buildings, or beside modern buildings. The Italian food was delicious, and varied. I was delighted with the amount of simple Italian vegetarian dishes, and pleasantly surprised when one of our guides told us that she grew in a small village, where her family had 300 olive trees, which they harvested every year. She said that they only ate a meat dish about once a month, and that most of the food they ate came from their own garden.

A few of us visited a winery, and tasted the freshest virgin olive oil, which was delicious. They also showed us how to make a basic pasta dish from scratch – flour, olive oil, egg, water and a rolling pin. I have since tried this at home, and it is delicious, along with fresh made pesto sauce.

Pompeii was an experience, and I was surprised at the large size of the city. There was one of the famous preserved bodies, which was preserved in volcanic ash, which has since turned to stone. Absolutely amazing! They are still continuing to excavate part of the city, as they are still finding more ruins. Hard to actually call Pompeii ruins, as walking down the cobbled streets, one could easily imagine city life before the volcano. What the volcanic ash and larva did was preserve that city in an instant.

Rome itself is amazing, and they are still accidently uncovering other parts of ancient Rome. The Romans don't like to have to dig any new subway tunnels or foundations for new buildings, as more often than not, they will find ancient remains, which then have to be painstaking excavated and preserved. Modern Rome has been described as a city built upon another city, and then another city, that goes back to ancient times. Rome has the enviable reputation of been one of the oldest functioning cities in the world. I was fascinated with the water fountains that were in the streets, everywhere, and was told that these are the original fountains that supplied the city and people of Rome with their water from the original, still operating ancient roman build aqueducts. We were told that the water in Rome, from these aqueducts is some of the cleanest water in the world. Because of its purity, this water, which is used in cooking, and baking, affects the texture of the bread, giving it particular flavours and textures.

Next year's conference is to be held in New Orleans, and I can only imagine how exciting it will be to explore this city, and listen to international speakers discuss important topics on health. And yes, I plan on going and this one will be number 18!.

Kimberley Bondeson, RDMA President

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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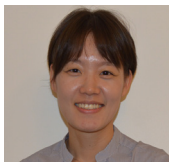

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RDMA 2017 MEETING DATES:

For all queries contact Anna Wozniak
Meeting Convener: Phone: (07) 3049 4444

CPD Points Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

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

RDMA NEWSLETTER DEADLINE

Advertising & Contribution 15 November 2017
Email: RDMANews@gmail.com
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NLMA 2017 MEETING DATES tbc:

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Meeting Convener: Phone: (07) 3121 4029
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W:www.northsidelocalmedical.wordpress.com

CPD Points Attendance Certificate Available

Venue: Rotating Restaurants

Time: 6.45 pm for 7.15 pm

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

Next Meeting Date 25th October 2017

RDMA Meeting for 12.09.17

Dr Kimberley Bondeson, RDMA President Introduced the Sponsor NeoTract Representative Donna Clark who in turn introduced the Speaker for the night: Dr Jo Schoeman, Urologist, Topic Minimally Invasive Surgical Advancements for Benign Prostatic Hyperplasia.

Below:
Photo 1. Donna Clark NeoTrack Representative and Dr Jo Schoeman.

Clockwise:
Photo 2 & 3 Redcliffe & District Members enjoying the meeting and presentation.

Photo 4.
New Member
Dr Phillip Bushell Guthrie

Monthly Meeting

Redcliffe & District Medical Association Inc.

DATE: **Wednesday 25th October 2017**

TIME: 7pm for 7:30pm

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: Medtronic
7:40pm	Speaker: Dr Ben Dodd Upper GI and Bariatric Surgeon Topic: 'Weight Loss Surgery in 2017: Indications, operations, follow up, ensuring lasting success'
8:15pm	Main Meal, Question Time
8:40pm	General Business, Dessert, Tea & Coffee

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

INSIDE THIS ISSUE:

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- **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.**

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

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AMAQ BRANCH COUNCILLOR REPORT
Dr Wayne Herdy, North Coast Councillor

Mandatory Reporting, Health Insurance Reform, Loneliness

MANDATORY REPORTING is the hottest topic around today. It has been one of the most consistent lobbying topics by the AMA in the past two years.

Mandatory reporting of health professionals (by other health professionals) of medical conditions which might render the health professional unsafe to practice has had unwanted consequences. From the patient's point of view, impaired doctors have been unwilling to self-report to other doctors in case the mandatory report brings a promising career to a screaming halt, or at best creates barriers, such as practice under the supervision of bureaucratic eyes. Early this year, we saw high-profile reports of suicides by doctors who had not sought help. From the point of view of the doctor being consulted, the choice is to report, knowing that this can have no good outcome for the patient, or fail to report, which can attract significant penalties if identified by the bureaucrats.

Anecdotally, there appears to be a probability that most doctors consulted by other doctors break the law and refuse to report their colleagues.

This position, where patients are reluctant to seek help and doctors are prepared to break the law to protect colleagues, is clearly unsustainable.

Health professionals have the highest suicide rate among white-collar workers. And suicide is only the tip of a very deep iceberg.

That dilemma has been recognized by AHMAC (Australian Health Ministers' Advisory Council) only last month, in a discussion paper prepared for COAG next month.

AMA is advocating for the West Australian model, which exempts treating doctors from the obligation to report colleagues. The WA version of the national law was created 6 years ago and has a proven track record. AMA is further advocating for national uniformity in the rules.

Let us hope that common sense and humanity prevail when COAG considers the proposed reforms next month. Politicians will be reluctant to enact legislation which appears to increase the risk imposed on the public but at the expense of rising rates of physician suicide?

HEALTH INSURANCE REFORM is a less hot topic for doctors but a high-profile topic for the Federal government. It has very little to do with health care and everything to do with payment for health care. It is of more interest to doctors because it opens pathways to access private dollars than because it has any impact on patients' health outcomes. For a government, the Holy Grail is to encourage young people (who don't consume health resources) to join funds and pay private dollars for the resources that they don't consume, with the desired outcome being less public dollars needed to supply health resources for the public patients who are prepared to consume endless resources. Watch this space, but don't expect it to impact much on average life expectancies.

LONELINESS is starting to receive attention as a risk factor, if not a disease in its own right. American research has measured loneliness as a risk factor with health outcomes comparable to or greater than the effects of hypertension or hypercholesterolaemia.

This column is supposed to be about medical politics, and has little role in teaching my colleagues about clinical medicine. However, the demographic of my peculiar practice is heavily weighted with patients suffering from loneliness, and I can foresee more than a little difficulty persuading bureaucratic beancounters to expend taxpayers ' hard-earned cash on what appears at first glance to be a social problem rather than a medical problem with a measurable mortality rate.

Wayne Herdy, Branch Councillor

Interesting Tidbits NATTY MOMENTS:

MONDAY STUFF

Did I read that sign right?
TOILET OUT OF ORDER.
PLEASE USE FLOOR BELOW.
****

In A Laundromat:
AUTOMATIC WASHING MACHINES: PLEASE REMOVE ALL YOUR CLOTHES WHEN THE LIGHT GOES OUT.
****

In a London Department Store:
BARGAIN BASEMENT UPSTAIRS...
****

In an Office:
WOULD THE PERSON WHO TOOK THE STEP LADDER YESTERDAY PLEASE BRING IT BACK OR FURTHER STEPS WILL BE TAKEN.
****

In an Office:
AFTER TEA BREAK, STAFF SHOULD EMPTY THE TEAPOT AND STAND UPSIDE DOWN ON THE DRAINING BOARD.
****

Outside a second-hand shop:
WE EXCHANGE ANYTHING - BICYCLES, WASHING MACHINES, ETC.
WHY NOT BRING YOUR WIFE ALONG AND GET A WONDERFUL BARGAIN?
****

Notice in health food shop window:
CLOSED DUE TO ILLNESS...
****

Spotted in a safari park:
(I sure hope so.)
ELEPHANTS, PLEASE STAY IN YOUR CAR.
****

Seen during a conference:
FOR ANYONE WHO HAS CHILDREN AND DOESN'T KNOW IT, THERE IS A DAY CARE ON THE 1ST FLOOR.

AMAQ BRANCH COUNCILLOR REPORT
Dr Kimberley Bondeson, Greater Brisbane Area

Influenza Vaccinations, AMAQ Conference and Anti-Vaccination.

We are still seeing some influenza cases, it seems to be very much a prolonged influenza season. According to the "The Australian" (29/9/17), The World Health Organisation has recommended Australia modify its influenza vaccine next year, after it found the effectiveness of this year's jab in the southern hemisphere was sub-optimal. Vaccine manufactures are working towards improving the 2018 influenza vaccination, which will hopefully be more protective of some of the rogue viruses we have seen this year.

We are also seeing an unusually wet spring, with rain and storms right up and down the coastline.

The AMAQ Conference in Rome was once again, excellent and informative. There was a host of international speakers, as well as our own Australian speakers. Of interest, Dr Bob Brown presented a topic on the Electronic Health Records. To date, 20% of Australians are registered. In 2018, patient records are expected to be uploaded automatically unless patients specifically opt out. He described "'hidden documents'' in the My Health Records, which are hidden by the patients. The plan is that these ''hidden documents'' will only be seen by Accident & Emergency doctors who will have the facility to "break the glass" and access these hidden records. Will be interesting to see how this unfolds.

Another very fascinating presentation was by an Italian Doctor, Professor Andrea Grignolio. His topic was on the "…The roots of social resistance against vaccination''. In his presentation, he stated that Australia has the best vaccination program in the world, using cognition. Fear about vaccination began from its very origins – the protective cowpox, that was used to protect humans against smallpox, led to concerns that promiscuity between animal and human species could deteriorate man. Vaccination at its beginnings had a mortality rate of 2-3%. In the UK, in 1853, (the Vaccination Act of 1853) made vaccination mandatory. In 1898, The Vaccination Act allowed for "conscientious objectors".

He stated that today's generation is the first one free of infectious diseases. But what has also disappeared is the social perception of the disease (we do not see smallpox or polio anymore).

Italian census data revealed the following:
1. Only 2 out of 10 patients totally trust the vaccines
2. 8 % of patients decide not to vaccinate on the basis of information found on the internet.

Professor Grignolio went further onto explain: If you type "vaccination'' into Goggle; 71% of the results found will be on anti-vaccination.

Information found on the web is substantively given by doctors and scientists, however, it is difficult for the layman to distinguish between proper scientific evidence and unproven conspiracy theories etc.

Conspiracy theories are more successful than scientific explanations, because they are less complex and less counter-intuitive. They are understandable and therefore reduce stress and complexity to the reader. This is certainly one significant reason why unproven anti-vaccination theories and stories are taken on board by the community.

Further research found that 82% of US high school students are not able to distinguish on the Web the authenticity of an image, whether t is sponsored or not, they use the number of likes an article or image is given as how they determine its authenticity.

It is a new world out there, and I found this presentation particularly intriguing, as well as alarming.

Sincerely Kimberley Bondeson

CEO UPDATE:

AMA Queensland
LMA NEWSLETTER COLUMN

Mandatory reporting update

September saw some further movement on the push to change mandatory reporting laws.
Regular readers of my column would know that the Australian Health Ministers Advisory Council (AHMAC) announced in August that they would develop a discussion paper that would outline possibly recommendations for a nationally consistent approach to mandatory reporting, which would then be considered by the COAG Health Council at their November 2017 meeting.

AHMAC has come up with four options for reform (see Appendix A **in this document**). In September, AHMAC held a stakeholder forum which the AMA attended, represented by our Federal Vice President Tony Bartone. Other health professions, regulators, consumer groups and health departments from across the country were also in attendance. With such a diverse group it was always unlikely that there would be a clear consensus on the day, however there was a mood for change – although what that change may look like is still to be determined. Health Ministers want to finalise changes in time for legislative changes early in 2018, so whatever changes occurs, it is likely to be a relatively quick process. For its part, the AMA has prepared a submission to the AHMAC proposing the adoption of the 'WA model' across Australia, which is listed as Option 2 in the AHMAC paper. Our submission will be submitted by the end of September prior to COAG meeting in November to discuss its options.

AMA Queensland believes it is crucial to have healthy doctors and that this leads to healthier patients. The opportunities to design a system that supports practitioners and the public must not be squandered. We will continue to press our case for reform and will provide a further update following the release of the discussion paper in November.

If you are a doctor who currently treats other doctors or health practitioners or if you are a health practitioner who would like to seek support, please contact the Doctors Health Advisory Service Queensland on (07) 3833 4352 or AMA Queensland on (07) 3872 2222 for confidential advice.

Jane Schmitt, Chief Executive Officer, AMA Queensland

The Medical Journal of Australia • MJA
MEDIA RELEASE

POTENTIAL TO INCREASE ORGAN DONATION RATES

AUSTRALIA'S organ donation rate, could have been boosted from 16.1 donors per million population (dpmp) to 21.3 dpmp if all potential Donation after Circulatory (DCD) donors had been identified, find the authors of research published in the *Medical Journal of Australia*.

A large group of Australian researchers, led by Dr Sandeep Rakhra and Prof David Pilcher from The Alfred, analysed DonateLife audit data on patients aged between 28 days and 80 years who died between July 2012 and December 2014 in an intensive care unit or emergency department, or who had died within 24 hours of discharge from either type of unit, in the 75 Australian hospitals contributing data to DonateLife. The investigators applied ideal and expanded organ suitability criteria to determine the potential for DCD organ donation in Australia, and to compare this potential with actual DCD rates.

In many countries, DCD – that is, donations by patients in whom circulation has ceased but who are not brain-dead – accounts for an increasing proportion of donor numbers; in Australia, it accounted for 107 donors in 2014, or 28% of all deceased organ donations, the authors wrote.

The researchers analysed 8780 patient deaths. Of these, there were 193 potential ideal and 313 potential expanded criteria DCD donors, in whom organ donation had not been discussed with their families. Most were potential donors of kidneys (416 potential donors) or lungs (117 potential donors). Potential donors were typically older, dying of non-neurological causes, and more frequently had chronic organ disease than actual donors.

"Identifying all these potential donors, assuming a consent rate of 60%, would have increased Australia's donation rate from 16.1 to 21.3 per million population in 2014," Dr Rakhra and colleagues wrote. "The potential donors identified would have provided many additional organs for transplantation.

"Optimal identification of candidate donors and discussion with families at current consent rates would have resulted in a deceased donation rate of 21.3 dpmp, with DCD comprising 46% of all donations in Australia."

The authors suggested that, "processes should be developed in hospital critical care environments that facilitate evaluating every patient undergoing end-of-life care for their medical suitability and potential to donate."

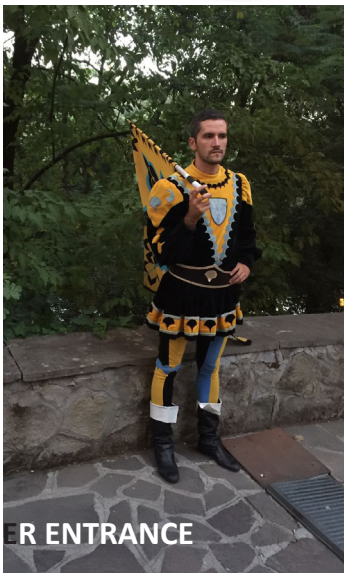
"The validity and cost of such routine evaluation should be examined. Assessing the potential for donation in hospitals outside the DonateLife network should also be attempted," they wrote. "Research into long term organ outcomes from ideal and expanded DCD donors would allow more informed donor criteria."

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

The *Medical Journal of Australia* is a publication of the Australian Medical Association.

AMAQ Conference in Rome
Pictorial by Dr Kimberley Bondeson


MY PASTA LESSON




CHEF GIVING PASTA LESSON


HEAD CHEF BETWEEN JOHN AND KAY MONRO


GALA DINNER ENTRANCE


GAYBRIELLA (KIMBERLEY'S SISTER) AT WINERY


KIMBERLEY AND GAYBRIELLA AT THE GALA ENTRANCE


GAYBRIELLA WITH JOHN & KAY MONRO AT WINERY

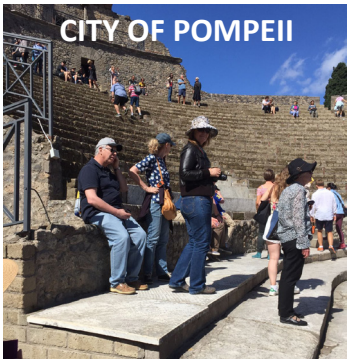

DR MICHAEL KENNEDY, GAYBRIELLA, AND DR MICHAEL KENNEDY SR IN HOTEL LOBBY

Continued on Page 9

AMAQ Conference in Rome

Pictorial by Dr Kimberley Bondeson *Continued from page 10*


PRESERVED PREGNANT LADY AT POMPEII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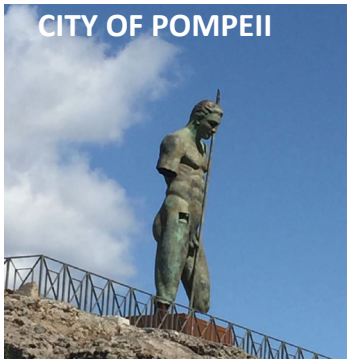
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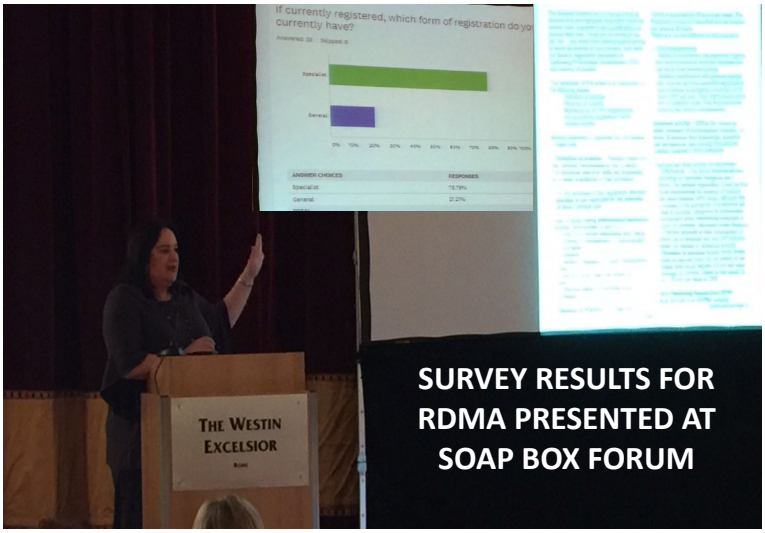
KIMBERLEY AT POMPEII


KIMBERLEY AND BILL BOYD AT GALA



SURVEY RESULTS FOR RDMA PRESENTED AT SOAP BOX FORUM


THE THREE TENORS IN ROME


DRS BOB BROWN, KIMBERLEY AND GRAHAM MCNALLY AT GALA DINNER


OPERA SINGER AT GALA DINNER

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AMA REJECTS PROPOSALS TO WATER DOWN ACCREDITATION STANDARDS FOR HEALTH PROFESSION TRAINING

The AMA has called Health Ministers to reject proposals that would water down the accreditation standards for health professionals, undermine patient safety, and involve more cost and bureaucracy.

AMA Vice President, Dr Tony Bartone, said that the proposals, made in the draft report of the *Review of Accreditation Systems within the National Registration and Accreditation Scheme,* would allow more bureaucratic and political interference in health workforce training.

The draft report recommends establishing a new agency, the Health Education Accreditation Board, as a single, national, cross-profession accreditation framework for health workforce education and training, and establishing Accreditation Committees to develop standards for the Board to approve.

"Accreditation has a critical role in protecting the public by ensuring the highest standards of education and training are in place," Dr Bartone said.

"Australia has a world class health system that delivers very good outcomes for patients. The results achieved are, in large measure, the product of a highly-skilled health workforce that is responsive to community need, and committed to innovation and continuous improvement.

"Independent, profession-led health workforce accreditation arrangements, where the safety of the public is paramount, are one of the strengths of the Australian health system.

"Patients should be very worried about the Review's draft recommendations, which would water down our world-leading accreditation arrangements and are deliberately designed to allow Governments and employers to push their own workforce agendas at the expense of patient safety.

"Imposing a one-size-fits-all approach to accreditation, including abolishing existing profession-led accreditation councils, does not reflect the reality of health workforce training or the context in which it is delivered.

"Instead, it will undermine the confidence of both the public and the professions in accreditation arrangements.

"It is very concerning that the review wants to see greater control of medical education and training being given to people with no training or practice in medicine.

"Unfortunately, the Review fails to recognise the innovation and reform that is already happening within the health workforce, as well as the proven record of accreditation bodies in establishing frameworks that support high quality training and education.

"The Review ignores this reality, and many of its key recommendations simply look like an attempt to address unfinished business arising from the 2005 Productivity Commission *Review of Health Workforce*, which is not surprising given that the Independent Reviewer also led that work.

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MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

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AMA REJECTS PROPOSALS TO WATER DOWN ACCREDITATION STANDARDS FOR HEALTH PROFESSION TRAINING

Continued from Page 12

"A great deal has changed since 2005, including a significant expansion of the medical workforce and other health disciplines. We do not need to revisit concepts that were rejected more than a decade ago and are of even less relevance today.

"The clear intent of the Review's draft report is to use accreditation to drive health workforce reform. This is a distraction from accreditation's key function – to maintain standards and protect the public.

"Health workforce reform would be much better dealt with by establishing an independent entity that can properly evaluate both the current needs and the impact of potential changes to the health workforce.

"The introduction of the National Registration and Accreditation Scheme (NRAS) in 2010 represented a very significant reform to the governance of health workforce accreditation arrangements.

"The Review has failed to make the case for major reforms to existing arrangements.

"The AMA believes it is too early in the life of NRAS to consider any significant reforms to the governance of accreditation. A more cautious approach is warranted, focusing on measured changes that build on and improve current systems and processes."

The Review is due to deliver its final report to Council of Australian Governments (COAG) Health Ministers for consideration before the next Ministerial Council meeting in November.

The AMA's submission to the draft report of the *Review of Accreditation Systems within the National Registration and Accreditation Scheme* can be read in full at https://ama.com.au/submission/ama-submission-independent-review-accreditation-within-national-registration-and-0

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16 October 2017

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AMA WELCOMES GOVERNMENT REFORMS AS GOOD START TO BRINGING MUCH-NEEDED TRANSPARENCY, CLARITY, AND AFFORDABILITY TO PRIVATE HEALTH INSURANCE

AMA President, Dr Michael Gannon, said today that the range of private health insurance (PHI) reforms announced by the Government provide a long overdue opportunity to bring much-needed transparency, clarity, and affordability to the private health sector.

Dr Gannon said that Australia needs a strong and viable private health sector to maintain the reputation of the Australian health system as one of the world's best, but the reforms will need the genuine commitment and cooperation from all stakeholders to deliver real value and quality to policyholders.

"The framework for positive reform of the private health insurance industry is now in place," Dr Gannon said.

"The challenge now is to clearly define and describe the insurance products on offer so that families and individuals – many of whom are facing considerable cost of living and housing affordability pressures – have the confidence that their investment in private health delivers the cover they are promised and expect when they are sick or injured."

Dr Gannon said the AMA welcomes the decision by Health Minister Greg Hunt to introduce Gold, Silver, and Bronze categories for PHI policies and that standard clinical definitions will be applied.

"Importantly, the changes will provide better coverage for mental health services and for people in rural and regional Australia.

"The AMA advocated strongly for standard clinical definitions on behalf of our patients. What we need to see now is meaningful and consistent levels of cover in each category.

"While we had called for the banning of so-called junk policies, we will watch closely to ensure that any junk policies that remain on the market are clearly described so that people know exactly what they are buying and are not subject to unexpected shocks of non-coverage for certain events or conditions.

"Basic cannot mean worthless.

"We will continue to call out any misleading products in our yearly report card.

"Other areas that will need further investigation include the fine detail of the new prostheses arrangements, how and at what level pregnancy will be covered, and the review of low value care for things like mental health and rehabilitation.

"We welcome the removal of coverage for a range of natural therapies such as homeopathy, iridology, kinesiology, naturopathy, and reflexology, which the Chief Medical Officer has rightly declared as lacking evidence or efficacy."

Continued Page 15

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AMA WELCOMES GOVERNMENT REFORMS AS GOOD START TO BRINGING MUCH-NEEDED TRANSPARENCY, CLARITY, AND AFFORDABILITY TO PRIVATE HEALTH INSURANCE

Continued from Page 14

Dr Gannon said the AMA has concerns about the possible direction of ongoing work on out-of-pocket costs and the review of privately insured patients being treated in public hospitals.

"We will be pushing for the expert committee considering out-of-pocket costs to broaden its review beyond doctors' fees.

"Doctors' fees are not the problem – 95 per cent of services in Australia are currently provided at a no-gap or a known gap of less than $500.

"The out-of-pockets committee must instead focus on the issues that leave patients with less support such as the caveats, carve-outs, and exclusions; hospital costs; and inconsistent and tricky product definitions.

"We will of course support efforts to rein in unacceptably high fees in the small number of cases where they occur.

"And we will be vigilant on any moves to deny private patients access to care in a public hospital. This is a critical and complex area that needs careful consideration. It is especially critical if the Government is going to promote basic and public hospital only cover.

"We are glad that the Government has listened to the AMA on Second Tier, an important defence against managed care.

"We welcome the enhanced role of the Private Health Insurance Ombudsman to address many of our patients' concerns about their private health coverage.

"The AMA will work cooperatively with the Government and other stakeholders to ensure that the reforms announced today deliver the desired outcome of greater transparency, clarity, affordability, simplicity, and fairness of private health insurance.

"We need to maintain the benefits we get from the balance between a strong public health sector and a strong private health sector," Dr Gannon said.

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13 October 2017

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CUBA:

by Cheryl Ryan

Cuba, a beautiful Latin country is famous for its revolutionary history and vivacious and modern Caribbean culture. Whenever you think of this nation, your thoughts may turn to revolution, cigars, tobacco and rum. But Cuba is much more than just these! Here, you will appreciate its lush countryside and pulsating salsa rhythms.

In addition to its rich history, this incredible country is also popular for its lively music scenario in Cuba and Trinidad with its eye-catching colonial architecture. With tropical islands and spectacular coastlines, Cuba is also a favorite destination for many beach lovers.

Cuba - A country with colorful history

The colorful and unique history of the country still dominates many aspects of the life of Cuban people. Havana is one of the most important destinations in the country where to experience history. A walking tour through the streets of Havana is an ideal way to understand the difference between the city life and country life in Cuba. You can visit the memorials dedicated to the world-famous revolutionary leader like Ernesto Che Guevara in Santa Clara.

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- Take a boat along the Underground River at the Indian Cave.
- Enjoy the beautiful views of Vinales Valley
- A trip to Trinidad, a UNESCO World Heritage Site and take a stroll through its cobble-stoned streets and mansions
- Relax, snorkel or swim at a beach in Cuba
- Pay a visit to the Che Guevara's Mausoleum
- Enjoy a night of Cuban Music

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Whats your Emergency Action Plan?

Scenario 1.
It is 7 am on a Monday morning, you get to work and there is fire & smoke billowing from your windows. The fire brigade are on site, what do you do next?

What is your emergency plan? An emergency plan is essential to all businesses to help implement a swift action plan & response.

Who are your emergency contacts? Where are these stored? Are they up to date? Who are your key contacts and do you have current details available?

Do you know if any staff are inside? Are they aware of the evacuation procedures? Workplace Health and Safety (WHS) obligations may vary between workplaces but there should be emergency plans in place.

As part of a good workplace action plan the response plan should be reviewed regularly, rehearsed, and updated for any changes.

Who in your office is responsible for this plan? What happens if they aren't around?

Scenario 2
Your computer shuts down, a message appears on your screen "You have been hacked, pay up $10,000 Bitcoin within 24 hours".

What is your action plan for this scenario? Who is in charge of the action plan?

What do you do first? Who do you call?

Does your insurance cover such an event? Are you sufficiently covered?

Do you have offsite backups? Are your phones linked to your computers?

As part of a good workplace action plan you should rehearse such a situation, talk to your IT providers and check your vulnerability, where are your emergency contacts held? Are staff aware of suspicious looking emails and do you have strong Spam filters set?

Scenario 3
A highranking staff member is killed in a car crash on the way to work.

What is your action plan for this scenario? Who is in charge? This situation is difficult and a response plan should be thought out.

Obviously you can't plan for all situations that arise, but what you can do is try to think of different situations and put in place a solid emergency plan. Rehearse, update, revise, review and backup.

If you keep Murphy's law ("Anything that can go wrong will go wrong") in the forefront of your mind whilst building your emergency response then chances are you will build a strong backup plan.

Over the years I have scene many scenarios experienced by clients flood, fire, death, injury, hacking, theft etc. The common response of those without a plan is, in hindsight ……

Don't get caught out, plan ahead. If you want to talk about any issues you may have that we can help with feel free to call. *Kerri Welsh – Manager Poole Group. 07 54379900.*

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IMPROVING COMMUNICATION BETWEEN HEALTH SERVICES AND DOCTORS

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

The AMA has released a new Guide, which sets out 10 minimum standards that should apply for communication between health services and general practitioners and other treating doctors to ensure the best possible health outcomes for patients.

The Guide, 10 Minimum Standards for Communicating between Health Services and General Practitioners and other Treating Doctors, which has been adapted from an AMA Victoria document, provides key criteria for communication that can improve quality of care for patients, and also reduce duplication and waste in the health system.

The AMA has written to all State and Territory Health Departments, and the major operators of private hospitals, urging them to use the new standards to inform the development of policy and to improve the standards of care being provided to patients.

AMA Vice President, Dr Tony Bartone, a Melbourne GP, said today that the AMA Guide encourages all health care providers and institutions to share the responsibility for improved communication across the whole patient journey.

“The Guide covers the patient journey from the community setting to treatment in a hospital or healthcare facility and return to the community – including clinical handover back to the patient’s general practitioner,” Dr Bartone said.

“Improving the communication between all the different providers in the health system can help to reduce re-admissions and minimise adverse events.

“More effective communication delivers improvements in satisfaction and experience for patients, carers, families, doctors, and other health practitioners.”

Dr Bartone said the development of the AMA Guide was led by GPs, who are often frustrated by the lack of timely information or inadequate information about their patient’s progress in the health system.

“GPs are the key coordinators of patient care, monitoring and managing their care and treatment. Any disruption to clear communication channels can have an adverse effect on patients,” Dr Bartone said.

“We are delivering very good outcomes for patients in the Australian health system, but we can and should do better. We are confident that the AMA Guide will contribute to improved communication and, in turn, better overall care.”

The AMA Guide covers vital criteria such as the timeliness of communication and its content; communication processes; the interface with practice software systems; good quality referrals, better discharge processes, and secure electronic communication systems.

The work undertaken by AMA Victoria has been well received in that State. The AMA believes the Guide can now play a similar role in driving quality improvement nationally.

The Guide is at https://ama.com.au/article/10-minimum-standards-communication

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The Burma Railway and Hellfire Pass cont:

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

The Thai–Burma Railway continued:

Remembering the railway

All memory is selective. Communities, like individuals, remember some stories of the past while forgetting others. For memories to survive at the collective or national level they need to be championed not just once but over the decades.

Many Australians have performed that role for prisoners of the Japanese. In the decades after World War II ex-prisoners published their memoirs and eye-witness accounts. Many of these proved to be immensely popular. Russell Braddon's The Naked Island (1951), for example, sold well over a million copies and stayed in print for decades.

The Workers

There were also memorable fictional accounts of captivity, some of which were adapted for commercial films and television series. The most famous of these was The Bridge on the River Kwai which, though bearing little resemblance to events in 1942-43, generated a popular interest in the railway which continues to this day.

In the 1980s Australian ex-POWs returned to Thailand and reclaimed Hellfire Pass from the jungle which had swallowed it when the Thai–Burma railway was demolished after World War II. The cutting soon became a site of memory for many Australians, particularly on Anzac Day. Its dramatic scale and its towering walls, scarred with drill incisions made by hand, spoke particularly vividly to the hardships endured by POWs along the railway.

The Building of Hellfire Pass

The building of the Hellfire Pass Memorial Museum by the Australian government in 1998 also made it a key site of memory, attracting tourists and 'pilgrims' of many nationalities. But 'Hellfire Pass' was more than just a cutting. In its vicinity a sequence of bridges and embankments were needed to keep the railway route along the escarpment level. There were also many camps housing the thousands of workers, including Australians. These have now disappeared into the exquisitely beautiful landscape but this website reclaims them as witnesses to the POW story.

The Anzac legend and Australian memory

Over the years this story of atrocity and suffering has become an affirmation of Australian courage and resilience. Although prisoners of war suffered the humiliation of being defeated and captured, they came to be portrayed as men who had triumphed over adversity. Displaying in captivity the qualities of humour, resourcefulness and mateship, they were able to integrate their experiences into the dominant national memory of war since the Gallipoli campaign of 1915, the Anzac 'legend'.

The POW experience is also remembered for service of the medical personnel who, with little equipment or medicines, cared for desperately ill men in primitive hospitals. Most famous of these doctors is the POW surgeon Sir Edward 'Weary' Dunlop. His statue now stands outside the Australian War Memorial, Canberra, not so far from another iconic image of compassion, Simpson and his donkey. Although Dunlop was only one of 106 Australian POW medical officers, in recent years he has come to represent them all—and the values of courage and compassion that they and many Australians manifested in captivity.

Military units to which the Australians belonged were broken up into work forces to meet the Japanese need for labour. From late 1942 more than 13 000 Australians were sent from Singapore, Java and Timor to work on the Thai–Burma railway.Around 12 000 Japanese and 800 Korean soldiers worked on the Thai–Burma railway as engineers or guards. They were some of over five million soldiers who served with the Imperial Japanese Army during World War II.

Continued next month.