

PRESIDENT'S REPORT 2009

Dr Ian Kamerman

The Rural Doctors' Association of New South Wales is the peak body for rural doctors in New South Wales. Formed as it was in 1987 out of the rural doctors' dispute it has a 22 year history and has as its heart an industrial relations solution in the form of the Rural Doctors' Settlement Package, whereby doctors in private practice can be adequately remunerated to interrupt their practice and service the emergency and acute care needs of the hospital.

Our organisation is continuing to grow with over 400 members in all areas of the state.

In those 22 years much has happened. RDA now involves itself in supporting rural practice, in working with rural communities, in education and training for rural practice. It has needed to because the threats and weaknesses that exist within rural practice continue to expand.

I am a rural doctor. I enjoy my work. I enjoy my patients. I enjoy my practice. I think we all should, and probably do unless burn out is affecting us. My worry is that in the context of rural health services in NSW the only good news that I have to share with you is at this individual level.

The state of medicine within New South Wales is becoming more and more parlous. This week I heard a study whereby the vulnerability of rural communities to the loss of their medical practices was assessed. They defined vulnerable communities to be served by either: a single solo practice, by more than 30% of the medical workforce being over 55, or more than 50% of the medical workforce being registrars. Out of the 216 rural communities, by this measure 128 are vulnerable. 61%. In addition there are other measures of vulnerability. Procedural practice remains on a proverbial knife edge. Historically obstetric practice was threatened in small centres, particularly those close to larger communities. Similarly we have had issues where procedural practice was reliant upon the skills of particular individuals. If those individuals left the community, the procedures usually followed shortly after. Now we have large communities losing maternity services. There are now at least 8 GP obstetricians in NSW who cannot practice intrapartum obstetrics due to either midwife shortages or financial constraints. This is a growing threat.

Our workforce problems are growing. The attrition rate in rural medical practice remains inexorable. Whilst there has been some



growth in general practice in rural NSW, it has not been matched by traditional models of rural medical practice that have existed in NSW. We are not seeing growth in the numbers of rural VMOs. GPs increasingly choose to abandon hospital practice.

Some of this will be resolved by the increasing exposure of rural based medical students to rural medical practice. It is important that we do not lose the impetus of this change to medical training. Hence the PGPPP and vocational training must include rural hospital practice. Whilst the Statement of Expectations from Minister Roxon to GPET mandates that 50% of all GP vocational training must take place in a rural area, it is theoretically possible for none of these doctors to get any exposure to the hospital practice that we feel is an essential part of rural practice. Our organisations need to raise this at a Federal level.

How do we maintain and support hospitalist practice. Sometimes the Settlement Package just isn't enough. Sometimes the Area Health Services mandate unreasonable workloads, using an all or nothing approach. We combat this with NSW Health when we hear of it. As Emergency Departments become busier in our larger and our tourist towns an appropriately remunerated sessional rate will be appropriate for some of our members and the support of CMOs for others. Area Health Services cannot expect VMOs to provide sessional services for fee for service rates. The Settlement Package is designed to support rural doctors in private practice, hence sessions are often problematic.

How do we encourage procedural practice? RDA believes that there has to be support and certainty. The NSW Government's Procedural Training Program provides recognisable training in a number of key procedural areas. RDA believes that this training program needs expansion. Currently the training must be done in a rural area. RDA believes that the quality of the training is much

more important than its location. The most vulnerable time for a new proceduralist is when they commence practice. Yet they have little or no support from this program. RDA calls for an expansion of the program to include a period of mentorship by the term supervisors to support the new trainee in their new practice. This would be in the form of visits to the actual communities, not often, but enough to assist with some of the difficulties that arise. It could also be an educational event for others within the town, such as is used within MSOAP.

Another barrier to procedural training is the lack of statewide credentialing. Currently each position in each hospital has a separate credentialing process. The progress we had gained was halted by events in Queensland and the South Coast. With the resolution of National Registration this needs to go back on the agenda. A GP competent to do deliveries in Armidale should be competent in Tumut.

Whilst not a state issue the RA fiasco has been a major source of concern for the RDA. We have worked with RDAA in an attempt to get changes to the homogeneity of RA2 that affects the southern half of NSW so badly.

In the course of the year RDA itself has made a number of changes. Along with the growth of our organisation we have put in place a central office in Gundagai with a dedicated office manager and also a bookkeeper. Not only to support the Executive, but also to provide a professional level of support to our members and stakeholders.

Communication remains a significant issue. Our new website is still under development. We want to use the web to provide a means of an up to date reliable method of letting the membership know what is going on around the state and also in their area. Once that is in place we will have a facility that will enable the launch of our new billing program. This program will be platform independent and also have the facility to be exported directly to payments at NSW Health.

I would like to thank Miriam and Tanya from our office in Gundagai. I would also like to thank my fellow members of the Executive for their work and advice over the year.

NSW Rural Doctors' Network / NSW Rural Doctors Association 2009 Rural GPs Conference

The NSW RDN / NSW RDA Annual Rural GPs Conference (formerly known as the AGM Conference) on November 26-29 was a resounding success. The quality of speakers was excellent and the NSW Health Minister, the Honorary Ms Carmel Tebutt engaged in an excellent discussion with attendees on the future of rural health in NSW.

We would like to thank our members who attended for taking the time away from their practice to be involved in this important conference, as well as the NSW RDN for all their efforts in organising.

For those who didn't attend, please make sure you consider organising locums and making arrangements early to ensure you can attend this year. We have strength in numbers and we would love to see every one of you on November 25-28 2010.

Membership Update

Membership now stands at 426 rural doctors in NSW. Our membership year is now 1st July to 30th June.

RDA NSW is one of the few representative organisations that is almost wholly dependant on membership subscriptions, and is run by a small dedicated group whose only brief is the interests of our members.

We need membership subscriptions to stay afloat so we appreciate members paying early and letting us know of any problems.



Please encourage other doctors and your registrars to become members of the Rural Doctors Association of NSW.

Membership forms are available at www.rdansw.com.au

NSW RDN / RDA (NSW) 2010 Summer Refresher Conference

The 2010 NSW RDN / RDA (NSW) Refresher Conference will be held at Opal Cove Resort, Coffs Harbour on February 26-28.

Topics for the concurrent sessions include Emergency Medicine – Paediatric Emergencies, Palliative Care, and Autism Spectrum Disorders.

Intending attendees are reminded to book early, and ensure they book their accommodation before Friday 29th January 2010 to avoid disappointment.

Booking forms can be downloaded at http://www.nswrdn.com.au/client_images/869649.pdf or contact the conference manager, Arna Wotherspoon on Tel 02 8337 8100 or Email conferences@nswrdn.com.au for enquiries.

Fee Schedule Item Number Enquiries

Dr Geoff White

Question

I am after an item number and rate for ESWL's (Extracorporeal shock wave lithotripsy). The procedure didn't exist in 1987 hence no item number or previous rate exists, I want to make sure all claims are correct. I am unsure as to why the multiplying rate changes so drastic - previous correspondence had said 2.433% and then I had article from newsletter says currently 1.486%.

Answer

If a Procedure such as ESWL didn't exist in 1987 MBS, which it didn't, you take the CURRENT CMBS Fee, for in this case, Item 36546 and multiply it by the current RDA/CMBS Multiplier which is 1.5130 (indexed annually on August 1st) to get the current fee for RDASP Hospitals. Multiplying the 1987 rate by 2.433 is correct only if the Item existed then which it didn't. The 2.433 is the Multiplier from the 1987 rate, the 1.5130 is the Multiplier from the current CMBS rate, reflecting of course that CMBS is indexed each year (on November 1st) too, but usually by a lesser amount than the RDASP.

SECRETARY'S REPORT 2009

Dr Paul Mara

I have been a rural doctor for over 27 years (almost as long as Wilson Tuckey has been a member of Parliament!) and was the third signed up member of RDANSW.

I would like to take the opportunity in this report to provide members with an indication of where we are as an organisation but also, given this experience, make a few observations.

When I returned to the executive of RDA I had a number of goals:

- Consolidation of the membership
- Implementation of an administrative framework that reflected the requirements of the organisation and increased complexity in which we all work
- Taking NSW Settlement Package administration to the next level
- Ensuring that RDAA became more responsive to the needs of grass roots practitioners

This still remains a work in progress but there have been significant achievements this year:

- The membership is now 425, slightly less than half of all doctors working in regional, rural and remote NSW.
- We now have a virtual fulltime office with high level support for the executive and members
- In January we will be releasing tenders for an online and integrated billing arrangement for the RDA Settlement Package
- RDAA has become more forceful in its engagement with government and other groups on behalf of grass roots rural

doctors and is seeking a mandate for constitutional reform that will, I believe provide greater transparency and ownership by grass roots members.

Membership is the lifeblood of any organisation. I want every doctor, specialist, generalist, and registrar in regional, rural and remote NSW to become, and want to become, a member of RDA. There is no reason why they shouldn't, whether they are hospital based and achieving the benefits of the RDA Settlement Package or doctors not working in hospitals but accessing significant commonwealth incentives, or rural specialists fighting for a better deal, or registrars wanting a worthwhile and viable career in rural practice, we all need RDA. Newer doctors should not forget that the RDASP came out of a bitter and costly 4 month industrial dispute. I would urge you all to check if all the doctors in your practice are members of RDA and if not get them to join.

RDA when it started was a purely voluntary organisation. Our practice secretaries did the books, and doctors and their families collated newsletters on the kitchen table. During his presidency Les Woollard fought for a more professional approach and I would like to pay tribute to the work Nicolee Woods did running the secretariat for a number of years with minimal resources. We now have an office dedicated to supporting the executive, ensuring membership is maintained and financial requirements met.

The RDASP has been the most visible sign of what RDANSW is about. Negotiated by Bill Hunter and myself over 22 years ago it has been protected and maintained by successive executives and basically stood the test of time. The indexation is consistently above any other medical package and is used as a benchmark against which all other states make their claims. The details of the package has been maintained solely by one doctor, Geoff White, almost since it was negotiated. The Association and all rural doctors past, present and future owe Geoff a huge vote of thanks. RDANSW has purchased, at a nominal cost, the intellectual property to the package and is developing this over the next year into an integrated online vehicle that will streamline billing and allow access through a variety of methods.

RDAA is set to change its constitution. Currently the only members of RDAA are the various state branches. It is proposed that all members of state RDAs will automatically become members under a framework designed to ensure greater input while still protecting the rights of individual states. Steve Sant RDAA CEO is to be complimented on the work he has done to further this reform. I would also thank the staff at RDAA for the support they have given RDANSW with the public relations campaigns, particularly in areas such as Pambula with obstetrics closure.

The past 27 years have seen a lot of changes in rural practice. We have seen a significant decline in procedural practice as the workforce crisis, both medical and nursing, bites deep. But the core aspiration of the association remains. We want to see people in rural and remote communities being able to access high quality health care locally wherever possible. This requires appropriately trained doctors and other health professionals and their families, dedicated to their communities and supported by a system that recognises their training, qualifications, skills and dedication.

RURAL DOCTORS LIAISON COMMITTEE

Thursday 10 December 2009

12.30pm – 2.30pm

Level 11 Conference Room

73 Miller Street, North Sydney

Outcomes

Many issues were discussed including a review of the list of which of the original list of 126 Hospitals remunerated VMOs at RDA Settlement Package rates [RDASP Hospitals]. These rates are indexed by a fairer formula than the Commonwealth applies to CMBS and is based on improvements on the original AMA ACT indexation formula.

Review of facilities under the Rural Doctors Settlement Package

The revised listing of current RDASP Hospitals is now complete, removing some from the Department list that never were RDASP on the original list or have closed or were Private Hospitals. From this revised list NSW Health had wanted to discuss 3 Hospitals: Bowral, Ballina and Shoalhaven.

Bowral has been deferred indefinitely due to RDA opposition. Ballina discussion remains on the table but deferred because Chris Crawford AHS CEO was 'not up to speed' with discussions so far.

Shoalhaven was then discussed:

Shoalhaven has 13 VMO Specialists, 7 staff Specialists and 2 GP VMOs. It does not have Obstetric Registrars currently and does not anticipate credentialling any more GP VMOs. 2 of the Specialists [ie 100% of the O&G Specialist workforce] are currently remunerated under RDASP. The Department were of the firm view Shoalhaven should not be RDASP. RDA insisted current users of RDASP not be disadvantaged but could not dispute presence of on site junior doctor presence 24/7.

Outcome: Liaison agreed that Shoalhaven be removed from the RDASP list of Hospitals provided.

A] there was Grandfathering of existing recipients – ie the 2 O&G Specialists and the 2 GP VMOs allowing them access to RDASP in perpetuity.

B] Beuladelah Hospital be added to the RDASP list

C] Other than Ballina which remains under discussion, no other Hospitals can be added or removed before 1/1/2012

Other Business

Remuneration arrangements for working shifts

Some AHSs are paying RDASP FFS whilst insisting VMOs stay for the entire shift, checking Path/correspondence/supervising other

docs. This is especially prevalent in coastal areas with high tourist presence.

The Department is also keen to limit RDASP to resident local Specialists, not fly-in fly-out Specialists as trade off for allowing elective sessional payment rates to RDA VMOs ie the Department wanted to link the two issues. The Department was not prepared to allow individuals to choose between 'fee for service' at times and an hourly rate with an RDASP Item number on other occasions initially.

RDA demanded a Base Rate be allowed. RDA refused to agree to 'Fly-in/out' doctors not having option of claiming RDASP rates. The Department response was that this might make Services too expensive so AHS might choose to only make some procedures available at regional centres where AMA/CMBS rates would apply. RDA suggestion of community service obligations fell on deaf ears.

Outcome: RDA to write to the Department suggesting a fee between 1076 [Committee] and 1058 [Ambulance transfer] for a new Item number [which has NOT been agreed to but demonstrates that the Department can approve it if it chooses as they requested the letter].

The Department agreed to forward PD2009, 1001, to Ian Kamerman demonstrating maximum capped hourly rates it allows for Locums.

Signed Invoices required by some AHSs sometimes.

RDA again objected to this as Clarifications says no other conditions may be added to billing requirements. RDA requested the Department write to all AHSs saying a signature is not required. The Department declined suggesting it represented good practice, was preferred by its Auditors and it differed from eg the Milkman because the milkman is requested to supply a list of goods but the VMO is self determining the service. This was refuted as of course we don't self determine a consult at 3AM in the morning. Ian Kamerman then made the excellent point that we all authorise the AHS to create RCTI's ie the AHS generates the Tax Invoices so we can't possibly sign a Tax Invoice we don't see until after the Claim has been paid.

The Department agreed that the letter it was to send to RDA, regarding the mention of Boards and Indemnity in our Service Contracts had not yet been sent, and advised it was work in progress of low priority as it was simply tidying up the Service Contracts to reflect developments eg loss of AHS Boards and Indemnity now compulsory by Medical Board.

Additional Matters

Ian Kamerman proposed NSW Health consider working with RDA on innovative models where Midwives employed by the Practice working under the supervision of doctors (who under new legislation can access Medicare could provide IntraPartum Care at the local NSW Health Public Health Facility with an RDASP Item number for a Midwife confinement) be paid to the Practice in the same way many Registrars Hospital earnings are redirected to

the Practice. RDA to write to Department regarding this for next Agenda.

The proposed RDA NSW/ NSW Health Liaison meeting dates for 2010 are as follows:

- Wednesday 10 March 2010 at 12:30pm
- Wednesday 9 June 2010 at 12:30pm
- Wednesday 8 September 2010 at 12:30pm
- Wednesday 8 December 2010 at 12:30pm

NSW Branch of the Royal Australian & New Zealand College of Psychiatrists (RANZCP) Rural Psychiatry Project

In 2009 the NSW Branch of the Royal Australian & New Zealand College of Psychiatrists (RANZCP) was successful in securing funding from the NSW Department of Health to undertake Phase II of the NSW Branch Rural Psychiatry Project (July 2009 - July 2012). Phase II of the Project builds on the many achievements of Phase I that ran between 2002 – 2008.

Below is a brief overview of the aims of the NSW Branch Rural Psychiatry Project as well as outline the key project objectives to be implemented during Phase II.

The overall aim of the project is to promote the development of a skilled rural mental health workforce and aims to support psychiatrists and psychiatry training in rural NSW through the implementation of a multifaceted approach to developing the rural psychiatry workforce.

The four key initiatives of Phase II are as follows;

Peer Support and Continuing Professional Development.

Many of you may have been involved in the Psychiatrist Council Meetings in the past, and this successful initiative will be continued during Phase II.

We will also be developing a Rural Psychiatry Professional Development Training Calendar which will incorporate discussion forums for rural based trainees and support workshops for the International Medical Graduate.

Clinical Leadership Mentoring Program.

This is a new initiative which aims to provide mentoring for clinicians in leadership and management positions across rural NSW, specifically Clinical Directors / Medical Superintendents.

It is proposed that the development of this program will be modelled on the RANZCP's Year 1 Psychiatry Registrars pilot mentoring program and framework.

Continuation of the Rural Psychiatry Recruitment Service.

The NSW Rural Psychiatry Recruitment Service developed in 2003 provides a specific framework for recruitment of Psychiatrists to rural New South Wales.

This service will continue as a free resource whereby psychiatrists and trainees can register their interest in working in a rural area online through the project website or browse the positions vacant section. This service is also available to Area Health Services and the private sector.

Further development of the NSW Rural Psychiatry Project Website. ([HYPERLINK "http://nswrural.ranzcp.org"](http://nswrural.ranzcp.org) \o "<http://nswrural.ranzcp.org/>" <http://nswrural.ranzcp.org>)

The website will be re-developed to provide a more interactive resource for rural psychiatrists and trainees. This will include access to the Rural Psychiatry Professional Development Training Calendar, as well as provide links to other learning opportunities.

The 'new look' website will also include an online forum, blogging and a photo gallery. Please look out for further updates on the project website in 2010.

A Project Steering Committee (Chaired by Dr Scott Clark) has now been convened and to date two meetings have been held. We are very pleased that Dr Scott Clark has agreed to be the Chair of the Project Steering Committee. A very productive planning meeting was held in November which involved lots of discussion, brainstorming and planning around the key project objectives.

As a result of this planning meeting, the first few months of 2010 are already shaping up to be very busy with many of the rural forums and workshops, as detailed above, will be held over February and March.

For more information about the NSW Branch Rural Psychiatry Project, please feel free to give me a call or forward me an email.

Ms Michelle Briggs

Project Officer

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Influenza in Children: The Facts

Influenza Specialist Group, A.B.N 30 121 203 343

What are the symptoms of influenza in children?

Influenza symptoms include fever, headaches, muscle aches and pains.¹ In children symptoms may also include nausea, vomiting and diarrhoea.²

How serious is seasonal influenza for children?

Influenza causes substantial illness in children every year.³ Of all vaccine preventable diseases, influenza is the leading cause of hospitalisation among Australian children under five years of age.⁴ Children are much more likely to contract influenza in any given season (20-50% compared with 10-30% in adults), with up to 70% of children contracting the virus during pandemic years.⁵ Not only are influenza infection rates generally highest among children, children also contribute greatly to transmission of influenza in the community.^{6,7} Healthy children under five years are more likely than any other age group to be hospitalised for influenza complications.^{3,6} Nearly 1,500* Australian children are admitted to hospital for laboratory confirmed influenza each year.⁸

How can you reduce a child's risk of catching influenza?

Vaccination is the single most effective way of protecting against influenza infection. Hand washing and personal hygiene, such as trying not to touch your mouth or nose are also important preventative measures; however, these are less likely to be practised by children. Where possible, avoid crowds when influenza is prevalent; again this is unlikely to be achieved with children attending day care, kindergarten or school.

Note: In controlled clinical trials remedies such as Vitamin C and Echinacea have failed to show any benefit in preventing influenza.

Which children should be vaccinated against influenza?²

Current Australian immunisation guidelines recommend annual influenza vaccination for anyone who wishes to protect themselves, which includes children aged six months or greater. It is critical that children at particular risk of severe complications from influenza are vaccinated, including those with:

- Heart conditions
- Asthma and other lung conditions
- Diabetes (type 1 and type 2)
- Kidney problems
- Impaired immunity

Pregnant women should also get vaccinated against influenza, including those in the first trimester at the time of vaccination and there is evidence that this may provide some protection for the new-born infant.⁹ People who care for or are in close contact with at-risk individuals, are also advised to protect themselves against influenza to avoid passing on the disease. Many other parents of healthy children aged 6 months or greater may also wish to get their children vaccinated, this is within National Health and Medical Research Council (NHMRC) guidelines.

What is the dosing and schedule for childhood influenza vaccination?

Children under nine years of age who have not been vaccinated previously are recommended to receive two doses at least one month apart, for the first year they get vaccinated (refer to Table 1).² In subsequent years, they only require one dose.² Some influenza vaccines available in Australia are packed in syringes for the paediatric dose (i.e. 0.25 mL pre-filled syringe ready for use)

* Based on population data that 105.8 per 100,000 Australians aged five years or less are hospitalised due to influenza and the current population figure for that group 15 1,371,051 (ABS accessed 5 March 2009)

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Table 1: Recommended doses of influenza vaccine

Age	Dose	Number of doses (first vaccination)	Number of doses *(subsequent years)
6 months-<3 years	0.25ml	2*	1
3-9 years	0.5ml	2*	1
>9 years	0.5ml	1	1

Source: NHMRC. The Australian Immunisation Handbook 9th Edition

* If a child six months to nine years of age receiving Influenza vaccine for the first time inadvertently does not receive the second dose within the same year, he/she should have two doses administered the following year. Two doses at least one month apart are recommended for children aged less than nine years who are receiving influenza vaccine for the first time. The same vial should not be re-used for the two doses.

How effective is influenza vaccination in the six month -five year age group?

No vaccine is 100% effective. However, clinical trials have shown that influenza vaccination is very effective in protecting against the severe consequences of infection, including among children.¹⁰ A two-year randomised study of children aged 6-24 months determined that >89% of children seroconverted to all three vaccine strains during both years¹¹ and in another study inactivated influenza vaccine was shown to be 77-91% effective¹² against influenza respiratory illness.¹⁰ Mathematical modelling has shown that vaccinating children under five years could decrease the incidence of influenza in the total population by 22-38%.¹³

What can parents do if their child falls ill with influenza?

Influenza is highly contagious and can be spread for up to a day before symptoms appear and for five days afterwards,² potentially even longer among young children. Ways to avoid spreading influenza include:

- Wash hands regularly
- Cover nose and mouth when coughing or sneezing
- Avoid physical contact with others
- Avoid mixing with other people, particularly those in a high-risk category, while contagious
- Don't return children to child care early, as they could still be contagious

Antiviral medications (including paediatric formulations) that can limit the progression of influenza if they are taken early after onset of symptoms (within the first two days of the illness) are available on prescription.

For further information on influenza please visit

www.influenzaspecialistgroup.org.au

References

1. National Institute of Clinical Studies. Flu Facts. Last viewed: March 2009. Available at: <http://www.fightflu.gov.au/aso/Index.aso?sld=211B&oage=influenza>
2. NHMRC. The Australian Immunisation Handbook 11th Edition 2008. Available at: <http://immunise.health.gov.au/internet/immunise/publiclnq.nsf/Content/HandbookMhome>
3. Milne BG, Williams S, May M et al. Influenza A associated morbidity and mortality in a Paediatric Intensive Care Unit. *CDI* 2004;28(4):504-508
4. Brotherton J, Wang H, Schaffer A et al. Vaccine preventable diseases and vaccination coverage in Australia, 2003 to 2005. *Communicable Diseases Intelligence* 2007;31(Suppl)
5. Neuzil KM, Hohlbeln C, Zhu Y. Illness Among Schoolchildren During Influenza Season. *Arch Pediatr Adolesc Med* 2002;156:986-991
6. Principi N, Esposito S, Gasparini R et al. Burden of influenza in healthy children and their households, *Arch Dis Child* 2004;89:1002-1007
7. Weycker O, Edelsberg J, Halloran M et al. Population-wide benefits of routine vaccination of children against influenza, *Vaccine* 2005; 23: 1284-1293
8. Newell AT, Scuffham PA. Influenza related disease: The cost to the Australian healthcare system. *Vaccine* 2008; 26 (52):6818-6823
9. Zaman K, Roy E, Arifeen SE et al. Effectiveness of maternal influenza immunization in mothers and infants. *N Engl J Med* 2008; 359(15):1555-1564
10. Bridges CB, Harper SA, Fukuda K et al. Recommendations of the Advisory Committee on Immunization Practices (ACIP): Prevention and Control of Influenza. *MMWR* April 25, 2003 April 25;52(RR08):1-36
11. Hoberman A, Greenberg DP, Paradise JI et al. Efficacy of inactivated influenza vaccine in preventing acute otitis media (ADM) in children [Abstract 752759]. Presented at the Pediatric Academic Societies' Annual Meeting, Baltimore, MD, 2002
12. Neuzil KM, Dupont WD, Wright PF, Edwards KM. Efficacy of inactivated and cold-adapted vaccines against influenza A infection, 1985 to 1990: the pediatric experience. *Pediatr Infect Dis J* 2001;20:733-740
13. Vynnycky E, Pitman R, Siddiqui R et al. Estimating the impact of childhood influenza vaccination programmes in England and Wales. *Vaccine* 2008; 26: 5321-5330

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Beyond this, Ultramedix are also introducing the attractively priced SIUI CTS-900 laptop style portable ultrasound this month.

The SeeMore USB and SIUI ultrasound systems are distributed by Ultramedix Australasia Pty Ltd.

www.ultramedix.com.au

email: [HYPERLINK "mailto:info@ultramedix.com.au" info@ultramedix.com.au](mailto:HYPERLINKmailto:info@ultramedix.com.au)

Tel. 1800 260 460

Workforce Enquiries

Our partner organisation, the Rural Doctors Network of NSW, handles all enquiries about Australian or overseas trained doctors looking to work in rural NSW.

They also have an excellent tool on their webpage to help medical students to determine which scholarships they are able to apply for.

They can be contacted on 02 4924 8000 or visit their webpage at www.nswrdn.com.au

Settlement Package Item Number Disk

Dr Paul Mara has prepared a new (interim) filemaker run time disk which will have all the functionality of Dr Geoff White's disk and will run on all computers.

The disk will be sent out automatically to all paid members at the end of this month. We apologise for the delay and confusion in the issuing of this years disk and thank Dr White for his invaluable contribution to the association by providing the disk service over so many years.

Planning is underway to complete an overhaul of Fee Schedule program functionality, including making the program accessible though our website by the end of the year.

If you, or other doctors in your practice, have accidentally let your membership lapse, you can pay by calling our office during business hours on 1800 350 732 or visit our website www.rdansw.com.au.

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