GPSpeak

Bundjalung Elders tell their stories

Also inside:

- The new Ice age
- Melanoma genes
- Weight loss drugs

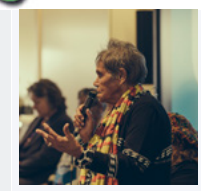
Quarterly magazine of Northern Rivers General Practice Network

Spring 2016

GPSpeak
Journal of the Northern Rivers General Practice Network

Published by:
Northern Rivers General Practice Network
PO Box 106, Lismore, NSW 2480
Ph: 0266 224453 Fax: 0266 223185
editor@nrgpn.org.au ● www.nrgpn.org.au

CONTENTS



Cover: This photo of Aunty Dorrie Gordon, taken by Kate Holmes, is one of the contemporary and archival images in the new book Our Way Stories, published by Arts Northern Rivers (see story on page 28). The book tells the life stories of ten local Indigenous Elders, in their own words - the prejudices faced by Aboriginal children growing up on the Northern Rivers, and the continuing importance of the living Bundjalung culture. Aunty Dorrie was the first Koori woman ordained as a minister in NSW, and for many years engaged in pastoral work in Grafton and Long Bay jails, and juvenile justice facilities.

EDITORIAL TEAM
Dr David Guest Chair NRGPN
info@nrgpn.org.au

Dr Andrew Binns Clinical Editor
info@nrgpn.org.au

Robin Osborne Editor
editor@nrgpn.org.au

Angela Bettess graphics | web design
angela@whiteduckdesign.com.au

GPSPEAK ON THE WEB

www.gpspeak.org.au

SEARCH

All articles in GPSpeak can be found by searching the website. Click the articles' links to directly access references and other resources mentioned in the the print edition.

SUBSCRIBE

Get the latest from GPSpeak by subscribing to the newsletter that comes out once or twice each month. Add your email address to the form in the right sidebar.

WRITE

Unless otherwise stated all articles in GPSpeak can be reshared under the Creative Commons Attribution-ShareAlike 3.0 Australia license.

GPSpeak welcomes contributions from members and the general public.

TWEET

Follow @gpspeak and comment on #gpspeak.

Editorial

Dr David Guest
NRGPN Chair

Huntington's chorea is an autosomal dominant disease that affects patients in their middle to older age with a progressive dementia and writhing movements of their face and limbs.

Since 1993, it has been possible to **estimate the risk** in the children of affected patients. However, there is no cure and many at-risk individuals have preferred not to know their status and carry on their lives in ignorance, if not bliss. Suicide rates in patients diagnosed as being positive can be up to 9 per cent. Patients testing negative may experience "survival guilt".

Testing for antenatal chromosomal abnormalities has also become increasingly available in recent years. Once again there are no trivial therapeutic options, with termination of pregnancy being an unacceptable choice for many people.

In the early 1980s there was no therapy for HIV and performing diagnostic tests posed similar ethical challenges for doctor and patient alike.

In medicine we are taught that if the result will not change the therapy, the test should not be performed. However, as we see in end of life care, a better understanding of the disease process and a more accurate prognosis may allow patients to cope with their disease.

This month's GP Speak reports on a study in melanoma risk assessment by researchers at The University of Sydney. Genomics has advanced significantly in recent years and it is now possible to estimate the genetic as well as the environmental risk for this disease. Clearly this information can be beneficial to such patients, allowing them to address at least their modifiable risks.

Also this month we report on local strategies financed by the government to address crystal methamphetamine (ice) use and addiction. As with other drugs, not all users become addicted but for the 25 per cent who do, ice can have major ramifications for themselves, their families and the community. The current ice education campaign needs to clearly spell out the dangers, but as a community we need to provide opportunities for problem users to get their lives back in order. This is tellingly recounted by a former addict in the article 'Getting Clean'.

Lastly, the Northern New South Wales Local Health District (NNSW LHD) and the North Coast Primary Health Network (NCPHN) are to be congratulated on their efforts to improve co-ordination between primary and secondary care.

The North Coast Integrated Care Wave finished in June 2016 and made important first steps in improving this collaboration. Continuing efforts in electronic communication, awareness of available services and pre-operative management of surgical patients are being made to improve the transfer of care between sectors. Several articles in this issue touch on these broad themes.

The Northern Rivers General Practice Network, as the local representative of the area's general practices, applauds the statements by the new Chief Executive of the NNSW LHD, Wayne Jones, on the seriousness with which he views improved patient care co-ordination across the whole sector.

As **Bogie says to Claude Rains** at the end of Casablanca, "I think this is the beginning of a beautiful friendship."

Getting your just deserts

Frozen rebates may sound like a new dessert - cold, quite tasteless but certainly not fattening. But in the medical sphere they have another meaning, and while some thought they were just a passing fad, it's now looking like they are here to stay.

As a result many general practitioners may be disappointed by the return of the Coalition in the recent election where health financing was a key area of difference between the two major parties.

Bulk billing rates are at record highs. To the economists of the Liberal Party this means the rebates are at least adequate. 'The market has spoken' and in these times of austere government spending it would be reckless to increase them.

The Medicare freeze originated with the Labor government in 2013 and was embraced by the Coalition when it came to power. The extension to 2020 announced as part of the Coalition's platform at the last poll came as a shock to many in the medical profession.

However, if bulk billing rates stay at their current levels there is no reason to believe the rebates will increase again in 2020. It's the market, dummy.

So, stop bulk billing... that's what everyone is telling you. It sounds easy enough. Yet, there are a couple of wrinkles.

The bulk billing incentive in rural areas is $9.25. You lose this if you do not bulk bill. The transaction costs for every consultation are probably a dollar or two and you may want to make up for the last three years of the freeze. For many patients in a region such as ours going from 0 to 18 dollars in out-of-pocket expense is a significant impost.

Ceasing bulk billing is simple enough for practices where the bulk billing rate is already low. The slight change in patient mix that results is compensated by the increased income.

It is much more difficult for practices that largely or exclusively bulk bill. They should expect a significant decrease in their patient numbers and subsequent income.

If making the change to private billing is not viable the options are stark; either cease whingeing or cease general practice.

The constant rebalancing of supply and demand is the hallmark of an efficient economy. This is achieved through the process known by economists as "creative destruction". It's the way of the future and the market is never wrong.

Anyone for dessert?

Gold Coast
PRIVATE HOSPITAL

GOLD COAST PRIVATE MATERNITY

- The perfect environment to welcome your special delivery -

The Gold Coast Private Hospital maternity ward features five birth suites, 25 deluxe private rooms with ensuites and a special care nursery with nine cots. We recognise that each of our expectant mothers has different needs and expectations which is why we work together with new parents to offer personalised care in a hotel style environment.

GOLD COAST PRIVATE HOSPITAL
14 Hill Street, Southport QLD 4215

goldcoastprivatematernity.com.au
PHONE: (07) 55 300 726

Weight gains trigger rise in drug demand

With the global obesity epidemic raging and suggested lifestyle modifications having limited success, the mounting pressures to seek pharmaceutical 'fixes' are hardly surprising.

Echoing the principle that everything old is new again, one of the notable weight loss medications is phentermine (Duromine), which has been available for many years. This amphetamine-related drug acts as an appetite suppressant. It has psychoactive effects and is only recommended for short term (up to three months) usage. While the drug does have some efficacy for quick weight loss to increase motivation or to help break through plateaus in a weight loss program, it has been found that weight regain is common once it is ceased. Further, it is contraindicated in patients with cardiovascular disease (CVD) or psychiatric disorder.

Fenfluramine/phentermine (fen-phen) was an anti-obesity drug that utilised two anorectics. But it was later found to cause potentially fatal pulmonary hypertension and heart valve problems, and was withdrawn. Likewise sibutramine was also withdrawn due to cardiovascular events and stroke risk.

Orlistat (Xenical) is a gastric lipase inhibitor which reduces energy intake through the partial elimination of dietary fats. However, if fat intake is above 67gm/day then steatorrhoea develops and this unpleasant side effect has resulted in this drug not having widespread use.

A new drug liraglutide (Saxenda) has come on to the market and was approved by the TGA in Dec 2015 as an adjunctive therapy for obesity. It is a glucagon-like peptide (GLP-1) receptor agonist. It was previously used in type 2 diabetes management at a dose of 1.8 mg daily. For weight loss a higher daily dose of 3 mg is used. It is in the same class as exanatide (Byetta) on the PBS for management of type 2 diabetes.

Saxenda is the first of the GLP-1s to be granted an obesity indication. It is an endogenous incretin, released by intestinal L-cells in response to nutrient ingestion, which enhances glucose-stimulated insulin release by pancreatic beta cells and acts on satiety pathways, including hypothalamic pathways, to reduce food intake.

Peripherally, liraglutide causes appetite to be suppressed and insulin production to be stimulated. Gastric emptying is slowed causing early satiety or a feeling of fullness after a meal. Gastrointestinal adverse effects such as nausea and vomiting also contribute to reduced appetite.

In a recent 56-week randomized placebo-controlled trial involving more than 3,700 adults the 3 mg liraglutide, in conjunction with lifestyle intervention, was associated with an 8.4 kg mean reduction in bodyweight, compared with 2.8 kg for placebo (lifestyle intervention alone).

Using the drug, 63% of subjects lost at least 5% of their initial body weight, while 33% lost at least 10%, compared with 27% and 11% respectively of those receiving placebo. It also achieves superior weight loss to orlistat. Liraglutide was also associated with a significant improvement in cardio-metabolic risk factors, including waist circumference, BSL, blood pressure and sleep apnoea. (1)

Further studies are needed to see whether the 3 mg product may have a role in patients for whom bariatric surgery has failed or is not appropriate.

The 3 mg liraglutide product is TGA approved as an adjunct to lifestyle measures for those with BMI 30 kg/m2 or higher. Also for BMI 27-30 kg/m2 plus at least one weight related co-morbidity (e.g. raised BSLs, hypertension, dyslipidaemia or obstructive sleep apnoea).

As regards side effects, nausea, vomiting, diarrhea, constipation, headache and hypoglycaemia are common. There are no long term safety data for the 3mg liraglutide product. It is associated with an increase in heart rate but the effects on CVD morbidity and mortality have not been established.

It is contraindicated in patients with a personal or family history of medullary thyroid cancer or with hypersensitivity to GLP-1 products. It should not be used in pregnancy or for treatment of type 2 diabetes.

It is not on the PBS and is expensive ($387 per month). It is recommended to use for one year, but to be ceased after three months if there is less than 5% weight loss during that time. GPs can register up to 10 patients into a support program, which will allow them to receive the first month's medication free, and one session with an accredited nurse educator.

GPs who consider using liraglutide for their eligible patients should study the product information. To assist with prescribing there is a patient support program available to work through the issues for recommending this drug and method of delivery. It is a daily subcutaneous self-injection.

The acceptability, duration of effect and long-term safety of liraglutide remains to be seen, but meantime patients may request this drug, as has happened in my experience, so it is best to be informed.

- Dr Andrew Binns

Astrup A, Rossner S, Van Gaal L et al. Effects of liraglutide in the treatment of obesity: a randomized, double-blind, placebo-controlled study: Lancet 2009; 374:1606-1616

Image courtesy of Global X at flickr cc-by-sa

Book review

The Gene - An Intimate History
Siddhartha Mukherjee
Bodley Head $26.95

When Charles Darwin's On the *Origin of Species* was published in 1859 all copies were sold on the first day, and, as we learn here, "A torrent of ecstatic reviews appeared almost immediately. Even the earliest readers of Origin were aware of the book's far-reaching implications."

A similar response greeted the publication of Professor Mukherjee's own first work, *The Emperor of All Maladies*, a history of cancer that would win a Pulitzer Prize for literature. It also became a Ken Burns documentary series (shown on SBS).

Somehow, he had fitted in writing that groundbreaking 600-pager around his clinical and academic duties at Cornell, the Mayo Clinic, Columbia University and more.

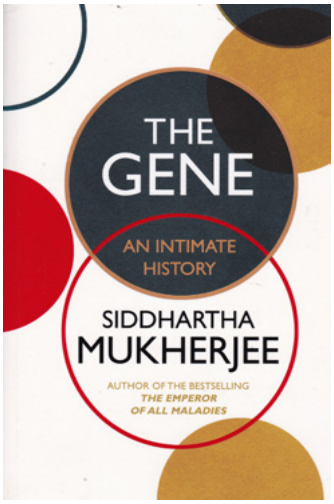
As he confesses in this equally impressive follow-up, he never expected to be lifting pen again, but then realised there was another story, the one around "normalcy before it tips into malignancy."

If cancer is "the distorted version of our normal selves", his focus would shift to "what generates the undistorted version of our normal selves."

Hence this book, hardly shorter than its forerunner, similarly impressive and immensely readable, despite the challenging nature of the subject material.

"In the early decades of the twenty-first century, we are ... constructing a new epidemiology of self: we are beginning to describe illness, identify, affinity, temperament, preferences - and ultimately, fate and choice - in terms of genes and genomes"

His gene journey opens and closes with several members of his own Indian family who had suffered profound mental disorders. Accompanying his father to visit Moni, a nephew with schizophrenia, in an institution in Calcutta, he notes that, "Madness, it turns out, has been among the Mukherjees for at least two generations, and at least part of my father's reluctance to accept Moni's diagnosis lives in my father's grim recognition that some kernel of the illness may be buried, like toxic waste, in himself."



By book's end, armed with immensely more information about genetics - as is the reader - he wonders about the "possible trajectories" of the relatives' lives if they had been born fifty or a hundred years from now.

"This book is the story of the birth, growth, and future of one of the most powerful and dangerous ideas in the history of science: the 'gene', the fundamental unit of heredity, and the basic unit of all biological information."

The early pioneers range from Darwin, the pea hybridiser Gregor Mendel - whose "garden plot may have been small... [but] not his scientific ambition" - and Darwin's brilliant cousin Francis Galton, "slung between the two giants of modern biology".

He coined the phrase nature versus nurture, although was unable to quantify the importance of each (not until the 1990s was it proven that genes that control IQ only become significant if the limitations of poverty, hunger and illness are removed).

Galton, a prodigy who knew Greek and Latin by age five, was the founder of eugenics, believing that the "continuous reproduction of soft-headed women and men posed a grave threat to the nation."

A 1912 exhibition on the subject included a German stand extolling 'race hygiene' - fast forward twenty years to the Nazis engaging in an array of 'purification' experiments.

A more humane version of the Nazis' ghastly (and discredited) twin studies was work in the 1980s "providing incontrovertible evidence that genes influenced homosexuality more strongly than, say, genes influenced the propensity for type 1 diabetes... and almost as strongly as genes influence height."

Regarding diseases, rather than traits, a child born to a parent with schizophrenia has from 13-30 per cent chance of developing the illness by age 60. If both parents are affected, the risk rises to 50 per cent.

The vast canvas includes the haemophilia gene running through Queen Victoria's descendants, including the Romanovs, and official American policies in the 1920s to sterilise 'mental defectives', who were often just people living unconventional lives.

We learn of chromosomal research and by the 1950s are with Watson and Crick, discovering the double-helix structure of DNA, and later the 'pajama' study on how subsets of genes allow an individual cell to respond to its environments.

Most genes, says Mukherjee citing Richard Dawkins, behave more like recipes than blueprints: "Human physiology, by analogy, is the developmental consequence of certain genes intersecting with other genes in the right sequence, in the right space.

"A gene is one line in a recipe that specifies an organism. The human genome is the recipe that specifies a human."

He concludes that if the lessons of history showed "the dangers of empowering governments to determine genetic 'fitness'... then the question that confronts our current era is what happens when this power devolves to the individual."

- Robin Osborne

Gene analysis targets life-saving melanoma prevention

At first glance, saliva may not seem closely related to the risk of acquiring melanoma, but successful results from a pilot trial indicate that the genetic identification of higher-risk individuals could result in reduced rates of this cancer in hot spots such as northern NSW.

Some preliminary results from the trial have been presented at recent international cancer conferences, and more results will be presented at the Sydney Cancer conference and Australasian Epidemiological Association conferences in September 2016.

It is known that where we live affects our predisposition to melanoma: Australia and NZ have the world's highest rates, with the greatest incidence in Queensland (and by association, far northern NSW), both nationally and internationally.

Who we are is also a key factor, as common genomic variants have a strong contribution to melanoma risk prediction.

Currently, the public is far more aware of the former risk factor than the latter, which is why this pilot trial* has such potential for improving prevention behaviours as well as psychosocial outcomes.

'Precision prevention' is how lead researcher Assoc Prof Anne Cust described it in a conversation with GP Speak.

"Direct to consumer testing is now available (particularly in the US) and advancing technologies have led to an explosion in knowledge about genomic risk factors for common, preventable diseases, particularly cancers," Dr Cust said.

"Translation and implementation of genomic information has predominantly occurred in diagnostic and treatment settings. However, genomic risk information also presents an innovative opportunity to improve cancer risk prediction, cancer prevention and early detection on a population level.

"We are interested in conducting research on key questions that need to be addressed if this type of information becomes more mainstream in Australian healthcare. E.g. how much genomic information should the public be offered? What are the experiences of people who have received genomic information, and how does it impact them behaviourally and psychologically?

"How should we equip health professionals to deliver genomic information? What are the experiences of health professionals who deliver genomic information to patients?"

Such questions, which sit at the leading edge of modern medicine, inform a project, that began last year with the participation of 100-plus members of the public statewide. The pilot study, being conducted by researchers from The University of Sydney, aims at examining the "feasibility, acceptability and impact" of providing people with information on their individual genomic risk of getting melanoma.

The results so far indicate that overall there was found to be a positive impact in terms of some enhanced preventive behaviours, and no negative impact on skin cancer-related worry or psychological distress.

Research Assistant, Amelia Smith, University of Sydney

However, a much larger planned trial will focus on determining such impacts more conclusively.

More than 13,000 new cases of melanoma will be diagnosed in Australia this year, making it the third most common cancer in both men and women. During their lives, 1 in 14 men and 1 in 24 women will be diagnosed with melanoma at some time. While melanoma accounts for only 2 per cent of all skin cancers, it causes 75 per cent of skin cancer deaths.

In the pilot's randomised controlled trial a sample of urban and regional NSW adults - including Northern Rivers residents - agreed to give a saliva sample for the purpose of the study.

Following analysis of the genetic material, the trial team provided personalised booklets outlining participants' genomic risk of melanoma, and educational materials on preventative measures to reduce these. Telephone-based genetic counselling was also offered.

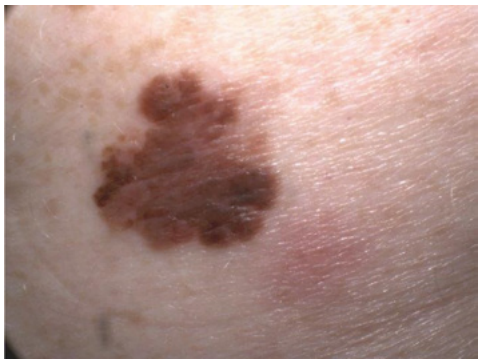
One example, for patient 'John', stated, "This booklet gives you an estimate of how likely you are to develop melanoma in the future. We call this an estimate of your remain-

cont on P 8

Genomic risk for melanoma (cont from P 7)

ing lifetime risk of melanoma.

"This booklet also describes how your remaining lifetime risk of melanoma was calculated, and what this risk means for you and your relatives... Based on your genetic risk, you are about 2.1 times more at risk of developing melanoma from now until the age of 85, than other men your age in NSW.



Melanoma

"This places you in a high risk category. However, this does not take into account non-genetic risk factors such as past sunburns..."

The booklets were also provided to the participants' GPs and the participants were later asked whether they had discussed the information with their doctors, families and friends.

The results showed -

- 41 per cent of high-risk patients had communicated their risk information with health professionals, 83 per cent with family, and 55 per cent with friends
- 17 per cent of average-risk patients had communicated with health professionals, 65 per cent with family, and 42 per cent with friends
- 13 per cent of low-risk patients had communicated with health professionals, 79 per cent with family, and 54 per cent with friends.

The researchers concluded that while conversations about melanoma risk and prevention occurred most frequently with family members, the higher the genomic risk the more likely patients were to discuss preventive behaviours and early detection with medical practitioners.

One female patient in the study is said to have booked a skin examination for each time she has a Pap test.

"The reasons for not communicating genomic risk included: concern about causing worry and not feeling a need to share the information," they added.

Participating patients reported high satisfaction with the personalised booklets and genetic counselling, according to the researchers, who concluded that, "Our results demonstrate feasibility and strong acceptability of providing personalised genomic risk of melanoma to the public, and suggest improvements to prevention behaviours."

These improvements may include -

- seeking shade, and reducing time in the sun during peak times (11.00am-3.00pm in the warmer months)
- using sunscreen
- wearing a hat and protective clothing
- avoiding intentional tanning
- having a partner or medical practitioner check one's skin.

Another important aspect of the pilot study has been seeking feedback from participating GPs via short telephone interviews about the booklet and asking how they feel their patient/s received the information provided.

GPs are also being asked broader questions, including -

- How is "genetics and genomics impacting on your practice and patient care in general"?
- Do patients show interest in genetic risk information?
- Should patients be given such information regardless of whether they request it?
- Should parents have children genetically tested?
- Could test results have either positive or negative impacts on emotions or behaviours?

Are health professionals and the system prepared for the way genetics is influencing health care?

The research will generate high-quality evidence on potential new cancer prevention strategies using genomics, taking into account key stakeholders' views, experiences and educational, support and training requirements.

This aspect of the pilot, titled Exploring the impact of delivering genomic risk information, is ongoing, and the participation of more GPs is invited by the research team.

For further information, contact Amelia Smit, Research Study Co-ordinator, on (02) 8627 1530 or **amelia.smit@sydney.edu.**

- Robin Osborne

Revalidation and Hume's guillotine

by Dr Nathan Kesteven

Philosopher David Hume, in his book "A Treatise of Human Nature" describes how hard it is to derive ought directly from is – that is, how tricky it is to logically demonstrate why things should be done in a certain way. This is often referred to as "Hume's Guillotine" as a way to demonstrate the severance of "is" statements from "ought" statements.

Now, as you would all be aware, **Australian Health Practitioner Regulation Agency** (AHPRA), is in the process of arguing that we all should (in fact, be forced to) undergo revalidation on a regular basis. This entails going from the "is" (concerns about medical practice) to the "ought" (you must practice in a set way).

In this article I would like to critique AHPRA's plan and show how the logic behind revalidation fails the "is" to "ought" argument.

Why does AHPRA want to force a system of revalidation upon us? A couple of years ago I read an article about this in "Aus Doc" magazine. The reasons put forward by Dr. Flynn, head of AHPRA, were: other countries have revalidation; there is concern about the safety of older solo doctors, and; the public is demanding that doctors get revalidated.

Firstly, there are other countries that have compulsory revalidation. However, there are other countries that have and do all sorts of things (the "is") so how can this then become the "ought"? I fail to see this connection. Certainly we can learn how other countries deal with the issues that the Medical Board deal with but I am not aware of any law or socially accepted mores that behooves someone or some group to act in a certain way just because another person/group does – particularly when the evidence behind revalidation is very poor (see below).

Secondly, the issue of older solo doctors appears to be of concern to AHPRA. In the article I read, these concerns were not spelled out, though allow me to quote Dr. Flynn; "there are concerns about older male doctors – those working in isolation, with little contact with their peers and little insight into their own practice. Often they are loved by their patients but that does not mean that they should still be working". In a recent survey (Oct 2012) by the Menzies Centre for Health Policy and the Nous Group: it found that there existed a high level of satisfaction with both GP and Specialist care (78% and 79% respectively) and over 85% expressed confidence in the quality and safety of their health care. So given these numbers is there perceived crisis in the quality of health care in Australia? The numbers do not lead to that conclusion. However according to this survey the most important issue that needed improvement, was access to medical and nursing staff. But what if this situation becomes worsen as a consequence of revalidation because "this does not mean they (the older male doctors loved by their patients) should still be working".

Now the reasons for revalidation have been dissected and shown to be scant, let us have a quick look at the evidence that supports introducing such a system. There seems to be very little to support it and certainly not enough to make a case to introduce it. In Plymouth University's study 'Evaluating the strategic impact of medical revalidation' Dec 2013 paper, the last paragraph concluedes, "there have only been a limited number of small studies exploring the impact of appraisal on performance and patient outcomes. Relatively little empirical evidence of revalidation's potential benefits exists, beyond opinions of its value from appraisers and appraisees."

Finally it has been been suggested there is public demand for revalidation. Now in my 20 years of practice I have yet to meet any patient who has said directly to me that we need revalidation of doctors, nor have I seen any mention of this issue in the popular press, so, without going too far out on a limb, it seems that the "public demand" is not so much public but rather reflects the agenda of the Medical Board.

So back to Mr Hume, the "is" is listed as "other countries", "older solo male doctors" and "the public". The "ought" is revalidation. And between them is a gulf as large as the Grand Canyon, as demonstrated above. It would seem that AHPRA on present evidence has fallen to "Hume's Guillotine".

Now I do not want to finish on a pessimistic note, so, for what's it's worth, here are my thoughts about what AHPRA wants to do and another way to do it.

I am imagining that AHPRA wants no complaints about doctors and no adverse patient events (and that they are hoping that revalidation will help do this). This is what any good medical practitioner would wish for. Why introduce a system that has lacks any support according to the available research and smacks of a paternalistic ideology when there is already an excellent and widely supported system which based on the most recent reviews, improves physician performance and has have some benefit to patient outcomes – Continuing Medical Education "CME" (**Effectiveness of Continuing Medical Education, Cerveo R.M., Gaines J.K., July 2014 ACCME)**.

May I simply suggest that in lieu of "revalidation" AHPRA engages with the Colleges responsible for our CME, reviews what is offered and based on what evidence is available in regards to effective CME, suggest changes to the this system that reflects the evidence that gets the most benefit. This would have the support of the wider medical community, be easily incorporated into the existing CME structure and be a change owned across the profession.

Image courtesy of Adam Jones, cc-by-sa

Getting clean - a former 'ice' user's story

Suzy (not her real name) went to a leading Northern Rivers high school but at 15 was lured away to Sydney by an older man who introduced her to the drug scene. During the next five years in "a different place and a different world" she got into speed, alcohol and marijuana, and eventually came into contact with the police, and the hospital system.

Back home, she felt estranged from family, and rebelled again, seeking out the local drug scene, and ending up involved with a biker club:

"I felt like I fitted in. I gained some protection and felt secure. I was being supplied drugs, so my addiction soared... there were a lot of females in my situation... it just ruined their lives really. I was hitting the drugs and alcohol really hard and notched up a few criminal records of my own."

Suzy now finds her past haunting her - when she applies for jobs her record often "bites me on the backside."

On the positive side, "I feel the only work I can do now is in the Drug and Alcohol field and I've studied to support that. I think they are the only people who are going to value my experience, so I'll keep following that path."

Drug addition wasn't a life

"Drug people, drug scene, drug houses, drug people... Once you start living that, that's what you live. You don't go for coffee at the local café, you don't do a big supermarket shop, you don't do those normal sort of things, you just go to houses where you know everyone is doing drugs and you only really associate with people where you can get on or get something free that day.

"There were times when I was homeless using drugs and not wanting to stay at a dealer's house for the next week using drugs. Now with Ice becoming more prevalent it's so scary, it's just a rabid drug. It's so strong, it's poison, it totally removes the person and it's just so evil and you are just an evil being, you totally lose yourself.

"Your existence is totally owned by this drug. Horrible. It's only making drug dealers richer. It's really dirty, if someone had told me back then what goes into this drug, there's no way I would have been doing it."

She says there are three main classes of addicts – the high functioning ones who have high profile jobs... Still functioning, they have access to things and because they have discipline they can pull it off. Then there are the ones like labourers who work hard all day and pay their bills, have kids, have that balance, they can do it all but they still use and dabble.

"And then then there are the ones at rock bottom who thieve every day to have a shot, they are walking the street at night trying to rob someone's car.

"In the end I had three children and I was married. I was living a straight life with my husband but of a night I was leaving the home to go and do drugs.

"At this point I started using ice. It was around 2010, at the age of 23. I put all my energy into a new relationship and when you are using drugs with someone you are so protected and you just rely on that relationship so much.

"My children were very young when this was happening and I'm grateful for that... over the last two years of that I was pretty much absent from the home.

"My ex just kept life so busy for them and my mother played a huge role in supporting my ex and the kids.

"I'm grateful for all of that but like a lot of families who are involved with this drug stage, it came to a point where I was told that I wasn't going to be seeing the kids anymore. "You need to go and clean up" and that's the point where I thought yes, and so I did.

Cleaning up

Suzy cleaned up with the help of the MERIT program, pioneered on the North Coast, and was referred to Cessnock rehab... "I talk about filling the circle you are in every day, as you have to exhaust yourself, because if I didn't have courses, I would have been sitting at home isolated, thinking 'I'll just make a phone call'. Because after everything I have gone through there is depression and people are social creatures and we need to be around people. Whether good or bad people, we do need them."

She went through the court system and got shared child custody... "The only people I see now are my children and the teachers at school drop off...

"I can wake up tomorrow and know that I have a fridge with food in it. I don't have people knocking on my door all night long. That life is so horrible and it's really hard for someone to understand unless you've done it."

At the recommendation of her GP, she sought help from a Drug and Alcohol counsellor, and being able to access both when needed has helped her feel safe.

"I think a lot of people still in the scene don't know what services are free. So I never knew if I was in a rehab that Centrelink pays for that. And then at the end of that you get a bit of money to get yourself some accommodation.

image under cc by sa license, author Radspunk

cont on P12

Local 'ice' strategy begins to crystallise

In a concerted effort to increase awareness of the realities and misconceptions surrounding crystal methamphetamine, a.k.a. 'ice', the North Coast Primary Health Network has begun a series of roadshows to promote better understanding of the drug's challenges amongst both the medical and general communities.

The program includes on-request briefings to GP practices and interested community groups, the most recent being an open symposium, 'Community Conversations - understanding and responding to crystal methamphetamine use is our community', in Ballina.

The low attendance at the event belied its importance, with participants including Duane O'Connor, counselor from the Aboriginal organisation Rekindling the Spirit, long-serving Northern Rivers police officer Det Sgt Mick Smith, psychologist Judy Rankin, and recovered ice user, 'Suzy', a proud mother of four, whose story accompanies this report.

The PHN's engagement campaign is being held in conjunction with the Bulgarr Ngaru Medical Aboriginal Corporation, further confirmation that the damaging and addictive drug continues to make significant inroads into the local Indigenous community. This sad fact was confirmed by Mr O'Connor who cited statistics showing that Aboriginal young people were much more likely to have taken ice than their non-Indigenous counterparts.

The PHN's push follows the current, nationwide focus on the drug - some of it ill-informed, as experts are saying - as well as the PHN's local effort that includes a taskforce forum last year, and the pre-election announcement of a $5.7M Commonwealth funding package to target the health aspects of ice on the North Coast.

According to PHN senior project officer, Substance Misuse Program, Samantha Booker, who is coordinating the practice and community briefings, around 2 per cent of Australians over 14 years of age have used ice in the past 12 months.

Ballina Mayor David Wright with the North Coast Primary Health Network's Ruth Taylor and Samantha Booker at the community symposium on combatting the spread of crystal methamphetamine (ice).

This figure is generally accepted, and despite frequent talk of an ice 'epidemic', it has barely changed in a decade. However, there are mounting concerns that Australian society could be on the cusp of a usage boom, largely due to changes in the manner in which crystal meth is being consumed.

These changes, according to highly regarded treatment expert and author Ted Noffs, of the famous Wayside Chapel family (www.noffs.org.au), result from the increasing purity of the drug.

"What Emergency medicine specialist Dr David Caldicott thinks we should be worried about is that methamphetamine is becoming purer, and that consumers are shifting from injecting to smoking it," Noffs writes in the recently published Breaking the Ice - How We Will Get Through Australia's Methamphetamine Crisis (HarperCollins).

He repeated his comments in a panel at the Byron Bay Writers Festival. This followed public discussion by Noffs and other experts, as well as former Premier Bob Carr, for the introduction of medically supervised 'ice inhalation rooms', akin to the successful injecting rooms set up for users of heroin.

Some consideration of this appears to have occurred at NSW Government level. However, Police Minister Troy Grant, the Nationals MP for the rural seat of Dubbo, has scotched the idea, raising the safety of community and staff, and adding: "Ice turns people into uncontrollable fighting machines and medical staff into punching bags. It's simply absurd."

Policing and rehabilitation remain the preferred strategies.

Noffs says that while some may see the switch from injecting to smoking as potentially positive because it could reduce blood-borne infections, the reduced 'yucky' factor may mean increased consumption by younger people, and especially girls.

Dr Caldicott has dismissed the notion of an ice 'epidemic' and the portrayal of all users as being prone to extreme violence, despite this fear being highlighted in the federal government's widely-run 2015 TV commercial - and the NSW Police Minister.

As he told Noffs, "The demographic changes in methamphetamine consumption are, to me, and in the long term from a public health perspective, far more concerning than the circulating moral panic suggesting that we've supposedly got axe-wield-

cont on P12

'Ice' strategy

(cont from P11)

ing cannibal people wandering the streets of Canberra or Sydney."

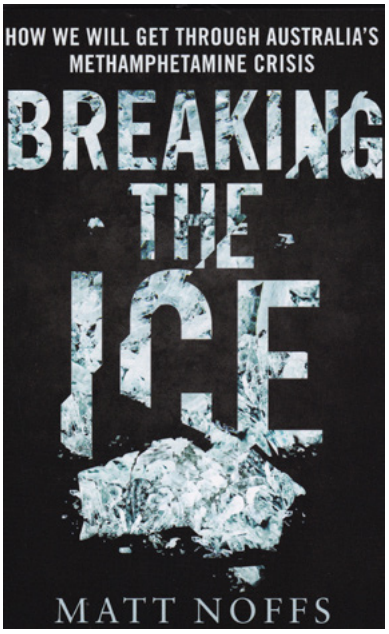
That said, between 25%-40% of regular users on the North Coast have experienced psychotic symptoms in the past month, according to the PHN's Samantha Booker, who says that while less than one-in-four users develops a dependency, the time to become addicted is much faster than with either heroin or alcohol.

It should be noted that a significant number of ice users engage in poly-drug use, notably cannabis and high levels of tobacco and alcohol consumption.

Ms Booker says the proportional use of ice crystal has grown much faster than the two less-potent methamphetamine forms (powder and base), adding that while the effects on the brain are rapid and pleasurable, despite a range of physiological risks, the coming-down period can be so unpleasant that regular users are often inclined to have more hits to maintain the high.

Significantly, and paradoxically, cognitive function amongst those who have been clean for as long as nine months has been found to be less than for current users.

Recovery from ice dependency is certainly possible, Ms Booker says, a view echoed by former addict 'Suzy', although the journey is seldom easy (Suzy certainly agrees with this),



especially for those exposed to peer pressure from drug users, or in circumstances where positive lifestyle options may be limited.

So far, no pharmacotherapy treatment has been found - i.e. no 'methadone' option - and ice dependency is best addressed through medical advice, counseling, support groups and lifestyle adjustment, with family understanding, rather than despair or condemnation, being a crucial factor.

As Dr Caldicott told Matt Noffs, "If you're a parent, try to learn what it means to consume that drug, and why your child is using it - it's not usually to piss you off... try to have a rational dialogue about what it is and the potential harms associated with it."

Further information -

Alcohol and Drug Information Service 1800 422 599

Drug and Alcohol Specialist Advisory Service 1800 023 687

Family Drug Support 1300 368 186

Free downloads -

Management of Patients with Psychostimulant Use Problems: Guidelines for General Practitioners www.nationaldrugstrategy.gov.au/internet/drugstrategy

NSW Health's Drug and Alcohol Psychosocial Interventions: Professional Practice Guidelines www.health.nsw.gov.au/policies/gl/2008/GL2008_009.html

Contact details

North Coast Primary Health Network - 6627 3300 -

sbooker@ncphn.org.au

Getting clean

(cont from P10)

"And people don't know about the Drug and Alcohol clinic Riverlands... some people think it's just for methadone and people wonder what do you have to do to get in there."

Less stigma, more hard facts

Suzy recalls, "The thought of being judged straight away when you go to hospital can stop you. If you are sitting in the ED waiting room with track marks and looking rat shit... you feel like you're the last person anyone is going to want to deal with.

"What we are doing is illegal, society doesn't want to accept it, society doesn't understand addiction and of course you are not going to go there because a hospital is to treat 'those people', not us.

"I wish the hospitals could have a section or a room where you could get that help, have a bed and dry out and then go to Riverlands, just so it can start to happen.

"GPs have to be brave enough to broach the subject...say to the patient 'your general health is shit and is a sleeping pill going to help you long term?'

"I think it would be really helpful to have a practice for addicts where you are not going to feel judged, and they can also access other information on services and support.

"What I'd like to see is at school is more drug education, we need to get quite graphic about it. If you told kids what they are putting into these drugs – chlorine, lighter fluid? any pharmaceutical drugs that are cheap and nasty and keep you awake... It's about saving a life.

We need to have more conversations with our kids around drugs... if they are at a party and they've had something which has caused a reaction, the fear of getting help is huge as they think they'll get into trouble with the police. What they need to do is just call the ambulance, the police don't have to be involved. I don't think all kids know that."

Region's best primary health projects chosen

The North Coast Primary Health Network (NCPHN) has chosen 12 finalists to contest the four categories in the Inaugural Primary Health Care Excellence Awards.

"These new Awards showcase the excellent work being done by GPs, allied health practitioners and community health workers right across the North Coast, from the Tweed down to Port Macquarie," said the NCPHN's Chief Executive Dr Vahid Saberi.

The finalists are:

1. Tresilian Lismore Family Care Centre - Enabling Service Provision through Partnership
2. North Coast Primary Health Network (Mid North Coast) - No Longer on the Backburner: Re-Developing Musculoskeletal Models of Care
3. NCPHN, NNSWLHD, Bulgarr Ngaru, UCRH, Solid Mob and NSW Country Rugby League - 1 Deadly Step, Casino
4. New Access - New Access initiative
5. Nimbin Neighbourhood & Information Centre Inc - Nimbin Independent Services (NIS)
6. NCPHN - Needs Assessment
7. New Directions - Mothers & Babies Program
8. NNSWLHD Renal Services and Bugalwena General Practice - Early Detection of Chronic Kidney Disease in Aboriginal People
9. NCPHN - Improved Health from the Winsome Health Outreach Clinic in Lismore
10. NCPHN - First Responders CPR Program
11. Bay Medical Centre, Byron Bay, Feros Care - eVillage
12. MNCLHD, Royal Far West & NCPHN - Nambucca Valley Healthy Kids Bus Stop

The '1 Deadly Step, Casino' is a finalist in the NCPHN's inaugural excellence awards.

Three finalists were chosen in each of the four Award categories with project topics ranging from the health of mothers and babies/young children, improving the wellbeing of disadvantaged people, and the eVillage in Byron Bay/Bangalow connecting Feros Care residents with GPs, specialists and the community.

Several of the projects focus on Indigenous health, including the 1 Deadly Step exercise program in Casino and the early detection of chronic kidney disease.

The final award judging will be announced at an event in Coffs Harbour on 9 September.

"The Primary Health Care Excellence Awards honour the partnerships, teams and individuals who work tirelessly to find new ways to keep community members healthy and out of hospital," Dr Saberi said.

"These Awards spotlight the often unseen efforts that help make improvements to health care outcomes in non-hospital settings.

"North Coast Primary Health Network has an ongoing commitment to fostering and recognising excellence in primary health care. We want to publicly recognise those who are making a real difference.

"Not just the finalists but all of the accepted entries are winners in their own way, although the true winners are the patients and clients whose health and wellbeing is benefiting from the efforts of our wonderful health care professionals," he added.

Health Minister 'honoured' by re-appointment

The first Turnbull government's Minister for Health and Aged Care, Sussan Ley ('Lee') has been re-appointed to the position in the second-term cabinet announced today (19 July).

Prior to the announcement there was speculation that Ms Ley would be shifted from the health role because of a comment during the election campaign about the government's freeze on Medicare rebates.

The Minister apparently believed the freeze - envisaged by the government to run until at least 2020 - should be ended. However, she said, this was not acceptable to the Finance and Treasury departments.

Ms Ley, who also holds the Sport portfolio, said she regarded it as an honour to continue in the role, which includes "protecting the future of Medicare and ensuring it remains universally accessible to all Australians, as well as tackling the growing burden of chronic disease through our Health Care Homes."

Health Minister Sussan Ley

Noting her passion for ensuring Australians live both longer and healthier lives, the Minister said her work would be "complemented by integrated reforms to mental health, medicines, hospital funding, rural health, aged care, dental, private health insurance, vaccinations, sports participation and preventative health."

She added that she looked forward "to continuing to work closely with stakeholders to ensure we appropriately balance the needs of patients with the need to protect the long-term sustainability of universal health care in this country."

This will be her sixth term as the Member for Farrer, the rural electorate in NSW that includes Albury, Griffith and Deniliquin.

Radiofrequency Venous Ablation (RFA)

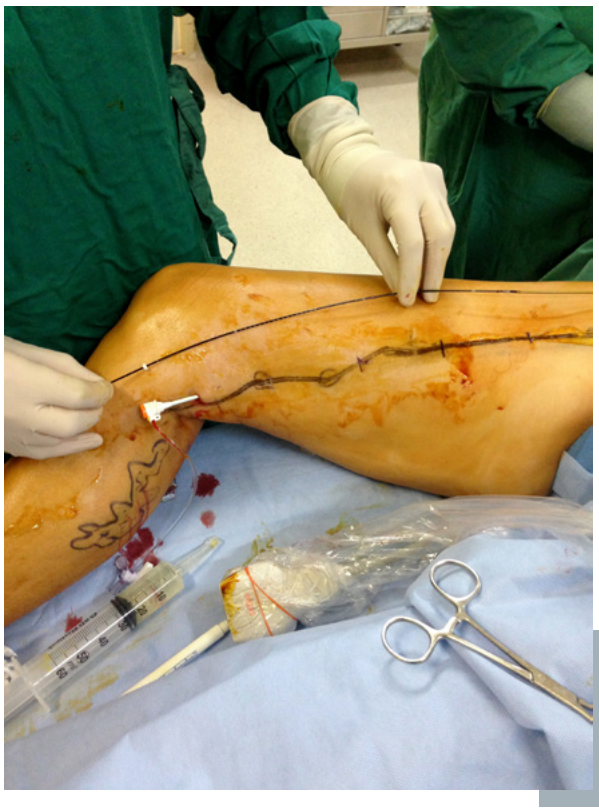
- a minimally invasive alternative for varicose veins

Dr Dominic Simring,
Vascular and Endovascular Surgeon
02 6621 6758
coastalvascular.com.au

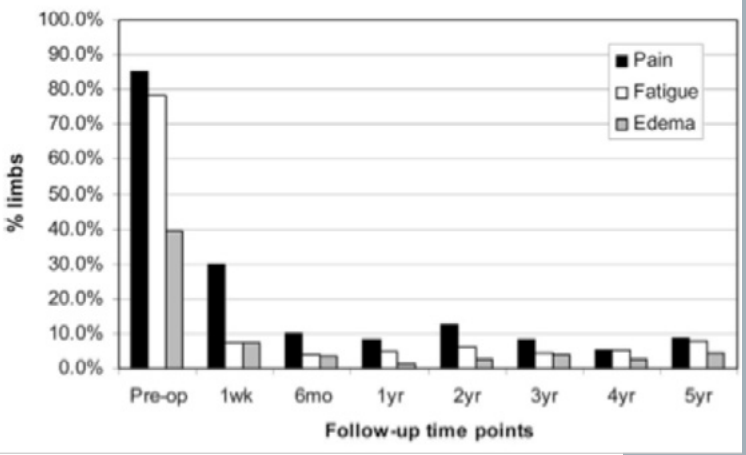
The treatment of superficial venous disease has undergone dramatic change over the past 10 years, with a movement away from open surgery (sapheno-femoral junction (SFJ) ligation and stripping). Surgery, though effective, is associated with complications such as hematoma, infection and paraesthesia. Further, there may be significant scarring in what is for many people a cosmetic procedure and recurrence rates of up to 50% have been reported . Chemical ablation with sclerotherapy, whilst performed commonly and with minimal risk, is often ineffective and expensive with high recurrence rates . Catheter based, minimally invasive thermal ablation of the long saphenous vein (LSV) has emerged over the past decade as a popular alternative to stripping surgery with randomised controlled trials demonstrating faster recovery, less post-operative pain, fewer adverse events and superior quality of life (QOL) scores .

RFA works via a catheter introduced through a needle hole in the distal thigh LSV and fed up to the SFJ (Fig 1). The catheter converts electrical energy to heat via a resistive circuit in contact with the vein wall – this causes shortening of collagen fibrils within the vein, luminal contraction and eventually fibrotic sealing of the LSV. Any branch varicosities may either be avulsed or injected at the same sitting – unlike sclerotherapy, which usually requires multiple sessions. The procedure is "walk in, walk out" performed under local or general anaesthesia (patient preference) and usually require no more than paracetamol or ibuprofen for analgesia. Patients are advised to ambulate frequently to avoid DVT formation, avoid heavy or strenuous exercise (though may return to normal ADLs/work within 1-2 days) and to wear Class 2 compression (20-30mmHg) stockings for a week.

The long-term outcomes for RFA are excellent – a clinical registry of 1,222 cases demonstrated an initial technical success of 97% with sustained results at 5 years (87%), a recurrence rate far lower than stripping surgery or sclerotherapy. Typical varicose vein symptoms such as pain, fatigue and oedema demonstrated significant reduction (Fig 2) over this period. Complications such as DVT and thermal burn were less than 1%, and are even less so now that RFA techniques have been refined , especially with the routine use of high volume dilute local anaesthesia tumescence.



The EVOLVeS study3, a randomised trial comparing RFA and surgical stripping once again demonstrated very few complications and a high rate of technical success in the RFA group. The main differences were lower pain scores, higher QOL/patient satisfaction scores and faster return to work and ADLs in the RFA group with 80% of RFA patients back to work within 24-48 hours. Again, these results were sustained out beyond 5 years suggesting that RFA is, in the long term, a viable option for vein treatment with low rates of recurrence.



1. Winterborn R, Foy C, Earnshaw J. Cause of varicose vein recurrence: late results of a randomized controlled trial of stripping the long saphenous vein. J Vasc Surg 2004; 40:634-639.

2. Hobbs J. Surgery and sclerotherapy in the treatment of varicose veins: a randomized trial. Arch Surg 1974; 109:793-796.

3. Lurie F, Creton D, Eklof B. Prospective randomized study of endovenous radiofrequency obliteration versus ligation and vein stripping (EVOLVeS). Eur J Vasc Endovasc Surg 2005; 34:19-24

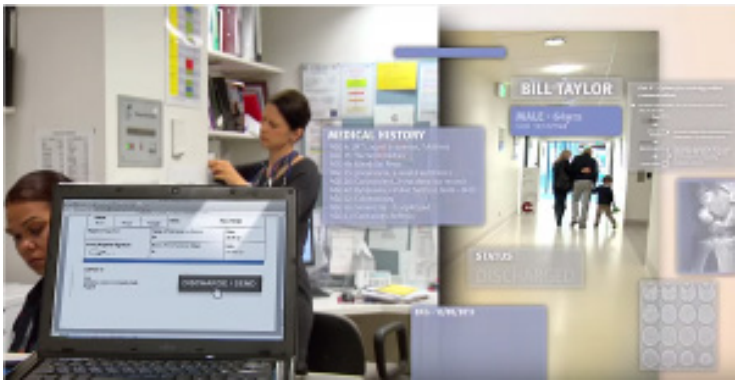
4. Merchant R, Pichot O, Long term outcomes of endovenous radiofrequency obliteration of saphenous reflux as a treatment for superficial venous insufficiency

COASTAL VASCULAR GROUP

My Health Record turns the big 4-M

"Every day one in five GPs will see a patient for whom they have little or no information at all - Health Minister Sussan Ley

More than four million Australians, about 17 per cent of the population, have registered for My Health Record, the Federal Minister for Health Sussan Ley has announced.



eHealth records explained from the Brisbane North PHN

"With a My Health Record, both a patient and their healthcare professional can gain immediate access to important health information on-line," the Minister said. "This can improve co-ordinated care outcomes, reduce duplication and provide vital information in emergency situations."

She said it enabled people to become more active in managing their health as well as providing links between the multiple services many may need through their life.

Ms Ley said a steady increase in registrations had followed the recent MH"Every day one in five GPs will see a patient for whom they have little or no information at all - Health Minister Sussan Ley re-launch.

"In the past four weeks alone, there has been an average of 2,200 new registrations every day, or one new My Health Record created every 38 seconds.

"With changes to the General Practice incentive, healthcare providers are increasingly contributing and viewing on-line health information about their patients. We are now seeing one upload of clinical health information from a healthcare provider every 21 seconds."

Ms Ley said every day one in five GPs will see a patient for whom they have little or no information at all.

"With the My Health Record, they will increasingly have access to at least some information about a patient. This may be a Medicare claim or pharmacy prescription, or clinical information uploaded by other healthcare providers such as a specialist, hospital and pharmacy."

Having a personal MHR "puts the power in the hands of health consumers to decide with whom they share their health information," she added.

Report shows more women and specialists, and aging GPs

The representation of female doctors in the GP workforce rose from 36.5 per cent to 42.1 per cent in the decade to 2015, according to the report *Medical practitioner workforce 2015*, released in late August by the Australian Institute of Health and Welfare (AIHW).

While this increase was less than that for female non-GP specialists, the proportion of women in general practice remains markedly higher than their specialist counterparts who account for only 20.9 per cent of that workforce component.

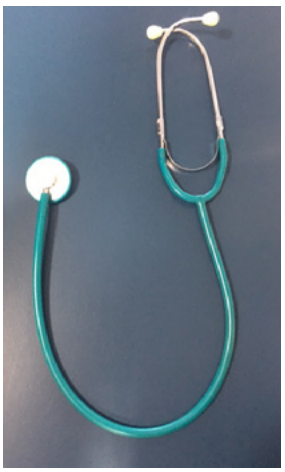
Overall, however, the supply of GPs changed little - ranging from 109 per 100,000 people in 2008 to 114 in 2015 (24,655 to 28,329 GPs).

The report also found that general practice had a higher proportion of older doctors than other clinician groups, with 40.5 per cent being aged 55 years or more.

Another significant finding was the shift in the past decade towards a medical workforce with more specialised roles.

The supply of non-GP specialists increased from 121 to 143 per 100,000 people between 2005 and 2015 (21,953 to 31,189 employed specialists). The supply of specialists-in-training increased from 43.4 to 74.8 per 100,000 people (7,268 to 15,336 specialists-in-training).

Most non-GP specialists were employed in the broad speciality groups of physician, surgery, radiology, obstetrics and gynaecology, paediatrics, and pathology.



The AIHW's Dr Adrian Webster said the findings suggest that "while the supply of GPs is keeping pace with population growth, the number of medical practitioners working in, or training to take on, specialist roles is growing faster."

Radiation oncology specialists at Byron Bay

Rapid access to advanced radiation treatment for publicly and privately referred cancer patients now available at Byron Bay Specialist Centre.

Dr Grant Trotter and Professor David Christie (Radiation Oncologists) attend the Byron Bay clinic once every three weeks. They have extensive experience in treating all major cancer types including Head and Neck, Lung, Breast, Prostate, Colorectal, and Skin malignancies.

For further information about our Byron Bay clinic service please contact our Tugun centre on (07) 5507 3600 or email: ccq.reception.tugun@genesiscare.com.au

Consultation clinic address:
Byron Bay Specialist Centre
Suite 6 / 130 Jonson Street
Byron Bay NSW 2481

www.genesiscancercareqld.com.au

Genesis Cancer Care Queensland

GenesisCare

Please feel free to contact us on 1300 212 555 to discuss service options. To refer; fax referrals to 0266 244 071.

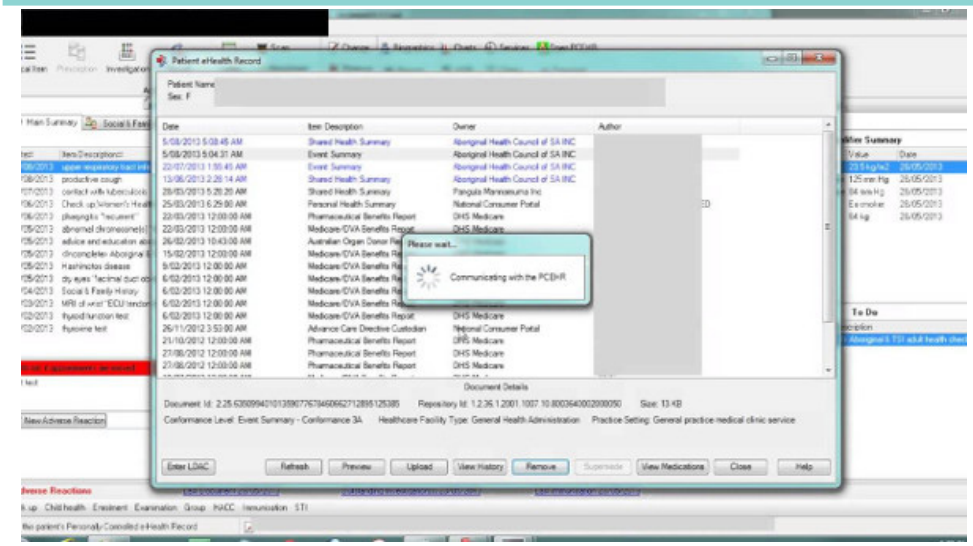
We would like to welcome Alysia Bonnett to our team at Embrace Exercise Physiology. Alysia will be working alongside Jesse Morgan to service the Lismore, Casino and surrounding regions.

Embrace
Exercise Physiology

Alysia became an Exercise Physiologist because she believes poor health should not be a barrier to an individuals life experiences.
Alysia completed her studies, a Bachelor of Sport and Exercise Science, and a Masters in Clinical Exercise Physiology right here on the far north coast at Southern Cross University. Upon graduating Alysia initially worked in rural and remote communities throughout far western NSW before moving back to the Far North Coast in 2015.
Alysia has over 3 years experience working with all aspects of chronic disease management and chronic injury rehabilitation. With a special interest in musculoskeletal conditions and postural correction.
Away from work Alysia enjoys finding a new challenge to add to her own training and exploring the local area and enjoying our beautiful region.

Embrace Exercise Physiology are a group of Exercise Physiologists servicing Tweed Heads, Lismore, Ballina, Casino, Evans Head and surrounds.
We specialise in exercise and lifestyle modification programs for the prevention and management of chronic disease and injuries.

My Health Record uploads



The eHealth component of Practice Incentive Program was tightened on 1 May 2016. Practices are now required to upload Shared Health Summaries (SHS) for 0.5% of the Standard Whole Patient Equivalent (SWPE) population each quarter to qualify for the Incentive. Quarters commence on the first of February, May, August and November. The incentive for a practice can be up to $12,500 per quarter.

The North Coast Primary Health Network has developed a **guide** to assisting practices in meeting their ePIP requirements. Section 4.6 of the guide shows how to determine the number of uploads in the preceding 3 months for three of the commonly used general practice electronic health records, Genie, Medical Director and Best Practice.

Uploads to the PCEHR

Medical Director has a specific tool to calculate the number of uploads for the quarter. For Genie users the guide runs through the process for extracting the details of uploaded Shared Health Summaries.

Best Practice has a query function to run Structured Query Language (SQL) queries directly against the database. Control-S brings up the Search box and the following query (see insert) can be pasted in and run.

Patient are listed by usual doctor and then surname.

The government hopes to increase the number of clinically useful entries in the My Health Record (formerly known as the Personally Controlled Electronic Health Record) system.

This is particularly important for those patients with chronic and complex diseases, who frequently attend hospital Accident and Emergency with potentially life threatening episodes.

```
select * from bps_patients p
inner join pcehrdocuments d on d.internalid
= p.internalid
where statustext = 'active'
and d.recordstatus = 1 and documenttype
= 1
and d.documentdate >= dateadd(month, -3,
getdate())
order by usualdoctor, surname, firstname
```

PHN in lead 10 for mental health reform

The North Coast Primary Health Network has been chosen as one of Australia's 10 lead sites for the roll-out of the national mental health reforms.

In this role the NCPHN will be a pioneer in primary mental health care reform, with work to include testing models of co-ordinated care for adults with severe mental illness and complex care needs, including approaches to assessment, referral pathways and packages of care.

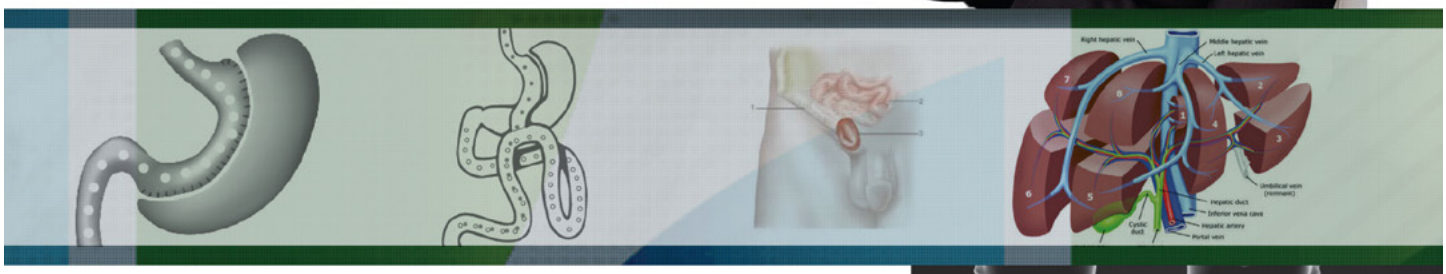
These models are likely to be tested in small cohorts in some regions. Implementing a systems approach to suicide prevention will also form part of its Lead Site work.

The NCPHN will work alongside consumers, carers and service providers to develop and model innovative approaches to regional planning, integration, low intensity services and stepped care in primary mental health care.

The work will be monitored and evaluated using a structured trial framework. Learnings will inform reform in other regions across the country.

The awarding of this opportunity is a reflection of NCPHN's strong stakeholder relationships and the ongoing collaborative work within the mental health sector in both the Mid North Coast and Northern NSW regions.

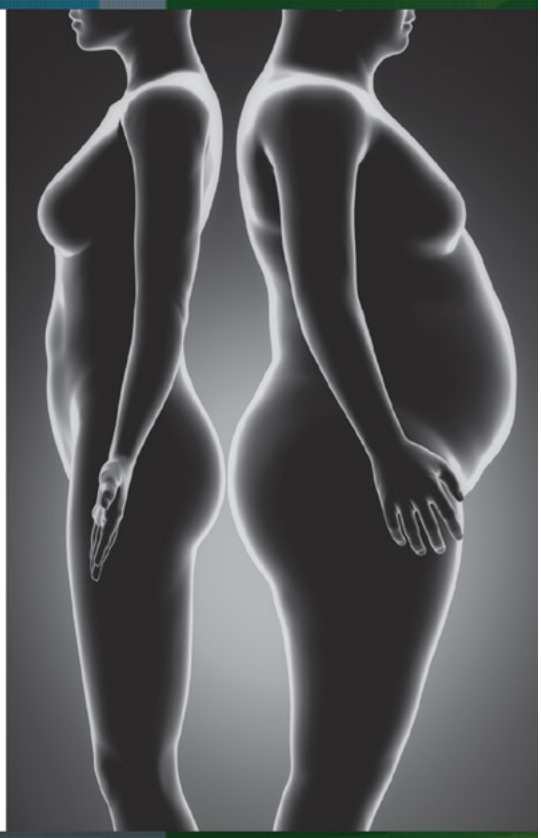
Harald Puhalla
GENERAL SURGEON



Assoc Prof Harald Puhalla, MD FRACS is an experienced general surgeon with a subspecialist interest in bariatric, hepato-pancreatic-biliary and upper gastrointestinal surgery. He was trained at the University Hospital of Vienna under the guidance of international leaders of surgery and has a particular interest in the latest surgical techniques, including minimally invasive treatment concepts.

With a PhD background and an interest in teaching and science he became the Professor of surgery for Griffith School of Medicine at GCUH, where he holds a public appointment.

Harald is known for his compassionate and holistic care to achieve the best possible results for his patients. His bariatric patients especially benefit from his close cooperation with highly experienced bariatric dietitians/exercise physiologist and psychologists.



Services:

- **Weight loss and metabolic surgery** (laparoscopic gastric sleeve, Omega loop gastric bypass, Roux-en-Y gastric bypass)
- **Cholecystectomy and bile duct exploration** (gallstones, advanced laparoscopic bile duct surgery)
- **Hernia** (laparoscopic repair of abdominal wall, inguinal and femoral hernia)
- **Hiatus hernia** (laparoscopic reflux surgery)
- **Liver and Pancreas surgery** (modern cancer treatment concepts with option of laparoscopic surgery)
- **Gastroscopy/Colonoscopy**

Assoc Prof Harald Puhalla is consulting at:

Pacific Private Hospital
Suite 3, Level 6, 123 Nerang St,
Southport, QLD 4215

John Flynn Private Hospital
Level 8, Suite 8B, Fred McKay House
42 Inland Drive Tugun, QLD, 4224

Regular operating lists in **Allamanda, Pindara** and **John Flynn.**

For more detailed information
www.generalsurgerygoldcoast.com.au

Contact Info | Assoc Prof Harald Puhalla

Letterbox 23 123 Nerang St, Southport, QLD 4215
Phone: 07 5503 1633 | Fax: 07 5503 1699 | E-Mail: admin@generalsurgerygoldcoast.com.au

The Next Big C

Dr David Guest explores some of the thinking behind the recent trend to commissioning of health services in Australia.

Although the Turnbull government has been returned with a slim majority, it now has the mandate it needs to continue its structural reform of the Australian economy. Informed customers choosing goods and services from providers in an open and competitive market place where innovation is fostered will maximise economic utility and lift productivity. This newly invigorated market place will apply to government services, including health, as well as to private industry.

The **Harper Review of Competition Policy** was a Coalition 2013 election promise. In receiving the report in 2015 the Federal Treasurer, Scott Morrison, agreed, "Effective competition encourages businesses to pursue efficiencies, rewarding the most innovative and dynamic that provide the best services at the lowest cost. It also benefits households by giving them more and better products and services to choose from at lower prices." The government rejected none of the 56 recommendations, accepting 39, partially accepting 5 and leaving 12 open for further review and consultation.

Recommendation 2 addressed Human Services and noted that;

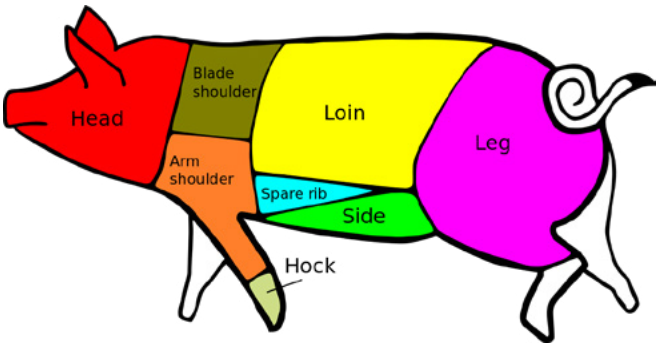
"Each Australian government should adopt choice and competition principles in the domain of human services.

Guiding principles should include:

- User choice should be placed at the heart of service delivery.
- Governments should retain a stewardship function, separating the interests of policy (including funding), regulation and service delivery.
- Governments commissioning human services should do so carefully, with a clear focus on outcomes.
- A diversity of providers should be encouraged, while taking care not to crowd out community and volunteer services.
- Innovation in service provision should be stimulated, while ensuring minimum standards of quality and access in human services."

Many of the areas examined in the Review are State or joint State/Commonwealth responsibilities. Like its Federal counterpart, the **NSW government has also embraced commissioning** stating, "Increased competition and innovation in public service provision can deliver significant benefits, and NSW believes that strategic commissioning is the most effective way to realise those benefits (such as achieving better value for money while improving service quality, creating contestability and incentives to innovate, and increasing accountability and transparency)." The NSW Treasury has established a Commissioning and Contestability Unit to further this approach within the public service.

To market, to market went my brother Jim
When somebody threw a tomato at him
Tomatoes are soft and they don't bruise the skin
But the one killed Jim was wrapped in a tin.



Some have been concerned that the commissioning framework has not been well understood by the public service. Federal and State Departments have been busy in the last 12 months **explaining** the **concepts** and **debating** the ramifications. Proponents emphasise that commissioning is not simply the outsourcing of traditional government services but entails continuous review of the marketplace's needs, services and the quality of those services.

The **Treasurer has asked** the Productivity Commission to look into which human services should be selected for the new approach. The suggestion that the Commission would identify areas currently covered by Medical Benefits Scheme was the partly the basis for the Labor Party's claim the government was considering privatising Medicare.

Such a claim was premature since the Commission is not due to **report** until September 2016. Nevertheless, the general thinking from the Productivity Commission can be found in their April 2015 paper, **Efficiency in Health**. Areas that affect primary health include:

- the reform of the PBS and MBS schemes (**the Robinson Review**),
- dissemination of evidence-based guidelines for clinicians (e.g. via **Health Pathways** or **Map of Medicine**),
- expansion of the roles of health care workers and their reimbursement under the MBS,
- allowing greater involvement of private health insurers in preventitive health and co-ordinated care,
- promoting the more efficient use of electronic health records,
- releasing more data on the performance of individual health care facilities and clinicians.

The **Horvath Report** restructured the Labor Party's Medicare Locals into Primary Health Networks. These PHNs were geographically aligned with the boundaries of the State governments' Local Health Districts. Being locally based and more attuned to the activities of the LHD, the PHNs are in a better position to evaluate local health problems and solutions than the Health Department in Canberra.

The new model of commissioning has thus fallen to them. The **PHN commissioning framework** envisages a process of:

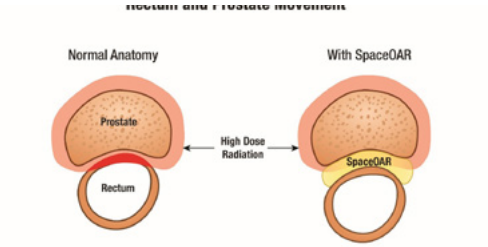
- needs assessment
- planning
- designing and contracting services

cont on P 21

Spacing Organs at Risk: Reducing Rectal Side Effects in Prostate Radiation Therapy

Professor David Christie and spaceOAR

Radiation therapy for prostate cancer is daunting. The thought of the potential side effects that may come with radiation treatment can be a cause of anxiety. Thankfully, here at Genesis CancerCare we are offering the latest technology to allay the fear of potential rectal toxicity.



Genesis CancerCare is pleased to offer SpaceOAR to suitable prostate cancer patients. SpaceOAR is a liquid that is injected between the prostate and rectum under ultrasound guidance. Once injected, the liquid solidifies within seconds into a hydrogel that pushes the rectum away from the prostate, thus reducing toxicity.

This procedure reduces radiation exposure to the rectum and related side effects during Intensity Modulated Radiation Therapy (IMRT) or Volumetric Modulated Arc Therapy (VMAT) for prostate cancer.

SpaceOAR is placed by urologists during the same procedure as gold fiducial marker seeds (used for positioning the prostate during radiation therapy treatment). The hydrogel maintains space throughout treatment and then liquefies, allowing it to be absorbed and cleared from the body within 12 months.

At our Gold Coast locations at Tugun and Southport, Professor David Christie (MBChB FRANZCR) is our specialised Radiation Oncologist for prostate carcinoma. He has a special interest in urological cancers including brachytherapy for prostate cancer.

Dr Selena Young and Dr Sagar Ramani are also available at our Gold Coast centres for consults on prostate carcinoma and spaceOAR placement. To find out more please call our GCCQ Southport Centre on (07) 5552 1400 or Tugun on (07) 5598 0366.

About Professor David Christie

David qualified in Medicine from New Zealand's University of Otago in 1987 and completed Radiation Oncology training in Sydney in 1995, at which time he moved to Queensland and commenced full-time practice. He is actively involved in research including national and international clinical trials. He is the editor of a Radiation Oncology medical journal and has published over 100 research papers. He has research and teaching roles with the University of New England as well as Bond and Griffith Universities.

Rural docs speak out on IMGs and rural incentives

Responding to a report in the Australian (9 Aug) that the Federal Health Department seeks the removal of 41 health roles, including GPs, from the skilled occupations list for visas, the Rural Doctors Association of Australia (RDAA) says such calls should be part of Australia's future medical workforce considerations.

It also wants an 'urgently required' National Rural Generalist Framework to get more Australian-trained doctors to the rural and remote communities that need them.

If the mooted change occurred, it would make International Medical Graduates (IMGs) no longer eligible to come to Australia under the visa class to work as a doctor.

"IMGs have made, and continue to make, an immensely significant contribution as valued local doctors in many rural and remote communities," RDAA President, Dr Ewen McPhee, said.

"In many cases, medical services in these communities would no longer be available if dedicated and long serving IMGs were not there to keep them going.

"For this, we owe past and present IMGs a huge debt of gratitude. But it is not right that we should continue to rely on enticing more and more IMGs from their own countries to prop up the Australian health

RDAA President, Dr Ewen McPhee

system, when we now have enough Australian-trained medical graduates to meet demand - particularly given that many IMGs come from poor countries with struggling medical systems."

Dr McPhee is pushing for greater incentives to encourage Australian-trained medical graduates with the advanced skills needed to work in rural and remote areas.

"While there are now enough Australian-trained medical graduates being generated through our medical training system, there remains a significant maldistribution of doctors — those doctors with the right skills are not necessarily going on to work in the rural and remote communities that need them most."

He said the RDAA had been a strong advocate for a National Rural Generalist Framework and an associated training program that would "provide medical students and young doctors with a seamless and dedicated pathway from medical school and the intern years through to work as a rural generalist doctor - while also providing those on the Program with training in the advanced skills needed for rural practice."

These includes procedural skills in obstetrics, anaesthetics, emergency medicine and general surgery, and non-procedural skills like advanced mental healthcare and Indigenous healthcare.

He added, "We are pleased that the Federal Government has set the development and implementation of the Framework as a key priority for the newly-announced role of Rural Health Commissioner. We look forward to working closely with the Commissioner and the Government to make it a reality, and to deliver to the bush the next generation of Australian-trained doctors."

- Robin Osborne

The Next Big C (cont from p 19)

- creating a supply structure (where needed)
- managing the suppliers' performance and evaluating the outcomes

It then repeats the process in a cycle of **continuous improvement**.

Mental health commissioning will be one of the first areas for the North Coast Primary Health Network to address. The details have yet to been released but may incorporate many of the principles described above with organisations competing for the contract to manage clients and devolving management to the lowest level of clinical competency. If successful, other services will undergo the commissioning process.

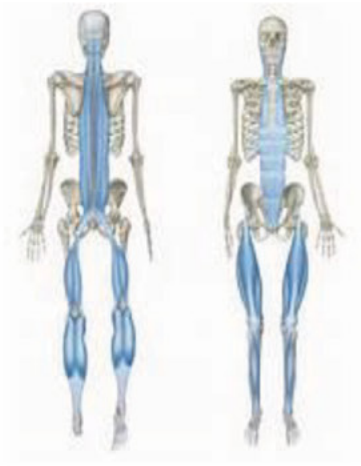
With the drive towards efficiency and value, the Primary Health Network, as a commissioning body, will have come a long way in 20 years from its origins in the Northern Rivers Division of General Practice. It may well have a difficult time balancing its traditional roles of supporter and facilitator in primary care with its new one of commissioner and arbitrator.

There has never been a more exciting time to be an Australian general practitioner or patient or even a Primary Health Network.

- Dr David Guest

Myofascial Release

Is this the missing link to your patients rehabilitation?



Myofascial Release – Optimising Rehabilitation

Alysia Bonnett, AEP - Embrace Exercise Physiology

As an Exercise Physiologist I see clients suffering joint pain, reduced mobility and flexibility and reduce functional abilities on a daily basis.

These individuals may be recovering from joint replacement surgery, a sporting injury, or have fallen victim to the ever increasing sedentary lifestyle and sitting culture.

Restoring mobility and reducing the impact of their condition on their daily life is often something they only dream of. Some people may have been in pain for several months or even years before trying exercise as an approach for relief.

Could fascia release be the missing link in their rehabilitation program?

Fascia becomes tight for serval reasons: if a joint has been immobile due to injury or surgery, naturally the structures will become tight. Constantly spending long periods of time in one position, e.g. sitting at a desk or driving for several hours a day can also result in fascia becoming tight over time. Poor posture or incorrect exercise technique on a repetitive basis is another cause.

If fascia release isn't considered as part of a rehabilitation program, an individual often falls short of regaining full function due to never achieving full range of motion as a result of tight fascia restricting movement.

Fascia release techniques were once limited to a trained therapist applying trigger point therapy. This was effective in the short term to improve mobility and reduce pain, however was never considered a long term solution.

However, with continued research into the benefits and scientific development of different forms of equipment, fascia release is now a relative inexpensive and wider accessible for of rehabilitation.

Who would benefit from a fascia release program?

Almost EVERYONE!

As a result of a changing lifestyle, and many of us becoming less and less active throughout the day a large majority of the population has some form of postural imbalance. Whether it be shortened hip flexors and tighten hamstrings from sitting for long periods, or upper cross syndrome

(tightness through pec muscles and weakness through upper thoracic region) due to incorrect desk set up or operating machinery with controls within a limited space.

Individuals recovery from a work place or sporting injury often have reduced mobility surrounding the site of injury due to immobility for a period of time. Much the same as those recovering from joint surgery, increased tightness surrounding the joint due to trauma.

Do you have patients suffering from joint pain, reduced mobility, reduced functional abilities, poor posture, recovering from a work place or sporting injury, or recovering from joint surgeries?

Get them in touch with your local Embrace Exercise Physiologist today, to start them on their journey to optimal function. Embrace can be contacted on 1300 212 555

Phone: 1300 212 555 Fax: 02 66 244 071 Web: embraceep.com.au

Embrace
Exercise Physiology.

Kevin Hogan
MP for Page

Order in the House

I would like to congratulate our North Coast Primary Health Network, which has been selected as one of four lead sites across Australia to implement the new $192 million suicide prevention program. This is exactly what I have been advocating to reduce suicide in our community.

Any suicide is tragic and unfortunately we have far too many in our community. Under this new programme, the North Coast PHN will receive millions of dollars in additional resources to develop localised methods to help prevent suicides.

Prevention activities across the North Coast will focus on community education, better integrating local services, and most importantly, ensuring better post-discharge follow up. One of the best ways we can prevent suicide is to ensure that someone who has attempted suicide or self-harm receives follow up support and treatment when they are discharged from hospital. At the moment, that doesn't always happen.

This new money will allow the North Coast PHN to work closely with our local hospitals and community based mental health services to ensure that when someone is discharged from hospital, they don't fall through the cracks and they aren't forgotten about.

*The North Coast Primary Health Network will work closely with suicide prevention organisations such as Black Dog and Beyond Blue to implement a range of localised strategies to reduce suicide rates across the electorate.

These new measures are in addition to a series of important steps, already undertaken in our first term, including the commissioning of regionally-delivered mental health services through the North Coast PHN in partnership with the NSW Government and local service providers.

* * * * * * *

As part of National Homelessness Week, I went to the Homelessness Connect event at The Winsome in Lismore on 4 August. It was wonderful to see so many people and community agencies working together. The Winsome and its volunteers do great work in our community. I thank them for that.

The Federal MP for Page, Kevin Hogan (Centre), with his wife Karen, and Paul Murphy, manager of The Winsome & Lismore Soup Kitchen, at Homelessness Connect day.

People caring for people

RAMSAY HEALTH CARE

John Flynn Private... because women's health matters!

John Flynn Private Hospital has world-class obstetricians and gynaecologists providing specialised care to women during every stage of life. Our team believe in empowering women to achieve their ideal birthing experience and treating women-related health issues with expert advice and caring professionalism.

Dr Genevieve Bishop
OBSTETRICIAN & GYNAECOLOGIST
Specialty: Obstetrics and Gynaecology, Uro-gynaecologist
Special interests: Incontinence and Uro-gynaecology

Dr Shiri Dutt
OBSTETRICIAN & GYNAECOLOGIST
Specialty: Obstetrics and Gynaecology, Fertility, Advanced Laparoscopic Surgery
Special interests: IVF/Advanced Laparoscopic Surgery, Endometriosis, Water Birthing / Hypno Birthing, High Risk Obstetrics, Prenatal Care and Delivery, Incontinence and Pelvic Floor Repair Surgery

Dr Neil Wallman
OBSTETRICIAN & GYNAECOLOGIST
Specialty: Obstetrics and Gynaecology, Fertility/IVF
Special interests: Water Birthing / Hypno Birthing / Calm Birthing, High Risk Pregnancies and VBAC, Urine Incontinence – Surgical Management, Recurrent Miscarriage, IVF

Dr Geoffrey Trueman
OBSTETRICIAN & GYNAECOLOGIST
Specialty: Obstetrics and Gynaecology
Special interests: Complete Obstetrics and Gynaecology service to patients

Dr Ash Hanafy
OBSTETRICIAN & GYNAECOLOGIST
Specialty: Obstetrics and Gynaecology, Fertility/IVF
Special interests: Minimally invasive Gynaecological Procedures, Laparoscopy, High Risk Pregnancies and Uterus Transplant

Dr Maneesh Singh
OBSTETRICIAN & GYNAECOLOGIST
Specialty: Obstetrics and Gynaecology, Fertility, Uro-gynaecology, Stem Cell Research
Special interests: Highly experienced Laparoscopic (keyhole) Surgeon and the only Robotic Gynaecologist on the Gold Coast. Obstetrician with Specialist Interest in Preterm Prevention and High Risk Obstetrics

Dr Suzan Elharmeel
GYNAECOLOGIST
Specialty: Gynaecology, Fertility/IVF
Special interests: Gynaecology, Laparoscopy, Pelvic Floor Surgery, IVF and Fertility Care

Dr Andrew Davidson
GYNAECOLOGIST
Specialty: Gynaecology, Fertility/IVF
Special interests: IVF specialist

If you would like to find out more about our comprehensive services available for women at John Flynn Private Hospital visit: **www.johnflynnprivate.com.au**
or phone: **07 5598 9000**

42 Inland Drive TUGUN QLD 4224

JOHN FLYNN PRIVATE HOSPITAL

Ironing out perioperative challenges

- Improving perioperative morbidity and mortality

Iron deficiency is a common problem in general practice. Traditionally it has been treated with oral tablets, intramuscular injections or intravenous administration. Each of these modalities have their own problems.

While tablets are first line therapy, they take several months to work and are associated with significant gastrointestinal side effects. Intramuscular injections are painful and may lead to staining of the skin. Previous intravenous formats of iron have been associated with serious side effects during administration, most notably anaphylaxis.

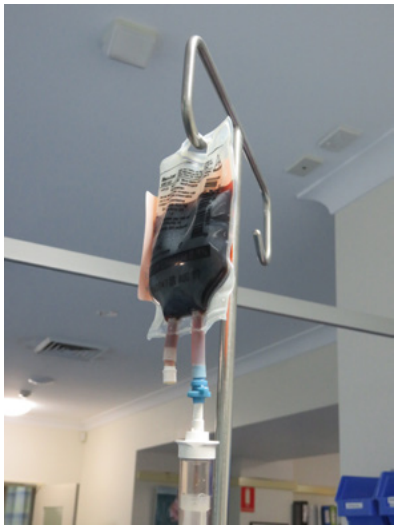
Rapid replenishment of blood and iron stores is needed for pre-operative patients where blood loss during or prior to surgery can be expected. Bowel surgery, gynaecological operations and major joint replacements are those where haemoglobin and iron replacement needs pre-operative optimisation.

Of the three groups joint replacements account for the majority of patients in the Northern Rivers presenting to surgery at risk of iron deficiency. However, bowel surgery patients were the most likely to have anaemia and they also pose the highest surgical risk.

The earlier iron treatment is started the better and iron infusions can be done in iron deficient patients with a positive faecal occult blood test (FOBT) even prior to diagnosis.

Iron deficiency is usually diagnosed on a blood ferritin level. However, ferritin is also an acute phase reactant and may be elevated in iron deficient patients with cancer or other inflammatory conditions. Such patients will have a raised CRP, normal ferritin and low iron saturation, so it is important to check CRP in conjunction with iron studies.

Ferric carboxymaltose (Ferinject) is a relatively new form of intravenous iron replacement that is associated with fewer side effects. As such, it is feasible to give in outpatient settings and larger general practice surgeries. Experience to date suggests high levels of patient satisfaction with this approach.



All facilities undertaking this new therapy need to have protocols in place to manage both the medical and legal risks of administering intravenous iron solutions. Checklists for the **indications, preparation** and **administration** help address these risks. Informed consent should be obtained and short pamphlets such as those from **BloodSafe** and the **NPS** cover the relevant issues for patients.

Nursing and medical personnel should be familiar with the issues involved in intravenous iron administration. The National Prescribing Service **Ferric Carboxymaltose Review** from August 2014 covers the essential points. Blood eLearning Australia runs online courses that includes a **module on Iron Deficient Anaemia** (IDA). The course is accredited for CPD points for the RACGP, ACCRM and the Nursing and Midwifery Board of Australia. They also have developed an IDA app for **android** and **iPhone** that quickly runs through the protocol for investigating iron deficiency in children, men and women.

Despite lobbying the Pharmaceutical Benefits Scheme (PBS) there is no general practice item number for intravenous iron infusion. Costs include consumables, that run between $10 and $20 per infusion, and staff time.

Ferinject comes in 500 mg ampoules. The maximum dose that can be administered in any one session is 1000 mg and should not be repeated in under a week. Most patients will require between 1000 and 2000 mg. Dosage can be calculated on ideal body weight and the level of haemoglobin using either the Ganzoni or "Simplified" methods both of which are described in the MIMS.

Administration of 1000 mg of Ferinject can be accomplished in 15 minutes via intravenous drip or bolus push injection. A cannula should be used to minimise the risk of extravasation that can cause tattooing of the skin. A "butterfly" should not be used because of the greatly increased risk of this problem. Patients are closely monitored for adverse reactions during and for thirty minutes after the infusion.

Haemoglobin levels climb slowly after an iron infusion, so it is recommended that a check haemoglobin level be delayed for six weeks after the procedure.

Iron infusions are now easy to undertake in general practice as **Drs Daniel Byrne and Pradeep Jayasuriya** attest. In the Northern Rivers the NNSW LHD is keen to liaise with general practices to improve the timeliness of iron infusions for those patients at risk of perioperative complications.

The North Coast Primary Health Network's **Iron Deficiency Anaemia Health Pathway** guides practitioners through the process with information specific to our area.

GPs requiring further information about local issues can contact Beverly Hiles at the Lismore Base Hospital preoperative unit, **Beverly.Hiles@ncahs.health.nsw.gov.au.**

NOVATED LEASES EXPLAINED

Wrapping a car into a salary package is a popular choice. Doing so by salary sacrifice often raises the topic of novated leases. Is it worth it?

WHAT IS A NOVATED LEASE?

Simply put, a novated lease is a way for an employee to buy a new or used car and have their employer assist in the organised repayment for that car to an agreed financial supplier.

The way this is done is by the employer agreeing to make the repayments out of the employee's pre-tax salary in a salary sacrifice arrangement which, like any such arrangement, reduces the employee's taxable income. The terms of the lease repayments are calculated according to the employee's earnings and the amount salary sacrificed.

A novated lease is therefore a three-way deal – between an employee, a financier, and the employer. The employee leases the car, and the employer agrees to make the lease repayments to the financier for that car as a condition of employment.

For these arrangements, one obvious such condition is to remain an employee. In the event that employment ceases, the obligations and rights under the lease revert to the (former) employee.

This can suit the person involved, as they keep the vehicle (and there are no tax consequences), but can also suit the employer as they are not saddled with an extra vehicle or a financial commitment to keep paying for the car.

During the period of the novated lease, the employer is entitled to a deduction for lease expenses where the car is provided as part of a salary sacrifice arrangement. But it does give rise to a car benefit under fringe benefits tax (FBT) rules.

FRINGE BENEFITS TAX

The value of the car benefit (on which the amount of FBT is based) is taken on the actual purchase price of the car. Working out its "taxable value" for FBT can be done using two available methods – the "statutory formula" method (the default and most commonly used), or the "operating cost" method.

The latter requires calculating the total operating costs of the car (fuel, oil, servicing, etc) and reducing that total amount by the portion of private kilometres travelled (which attracts FBT) as compared to the total kilometres. It is most often used where business kilometres travelled are high, but is more complicated and requires more records (logbooks) to be kept and calculations to be made.

With the "statutory formula" method, the taxable value is very broadly calculated at a flat rate of 20% of the purchase price of the car.

HOW YOU MIGHT SAVE TAX: POST-TAX CONTRIBUTIONS TO REDUCE FBT

The employer's FBT liability that arises from salary packaging a car through a novated lease can be reduced by the employee making contributions towards, say, the running costs of the car from after-tax dollars. It is important that these contributions come from after-tax salary, as every dollar so contributed reduces the taxable value dollar-for-dollar up to the total.

By doing this, rather than the employer paying the FBT tax rate (which is 49% for the 2016-17 FBT year) and passing it on, the employee typically pays tax at their marginal rate, which for many will be much less than that. Determining whether novated leasing is right for your circumstances can be a tricky exercise – contact TNR if you need assistance.

31 Keen Street
Lismore, NSW
PH: (02) 6621 8544

Thomas Noble & Russell

Accountants | Auditors | Business Advisers

‘Gross disparity’ in rural health research funding

A ‘gross disparity’ in the funding of research focused on rural and remote health issues continues, despite the fact that this 30 per cent component of the population has a higher rate of complex chronic disease and dies earlier than urban dwellers. Other challenges include a shortage of medical specialists, and the difficulty of accessing efficient and appropriate health services because of dispersed populations.

In the Australian Rural Health Research Collaboration’s newly released annual report, the Director, Associate Professor Megan Passey said that despite these challenges the ARHRC continues to work in partnership with rural health service providers to undertake rigorous research to generate locally relevant evidence on priority issues.

Dr Passey, works locally with the University Centre for Rural Health,

North Coast added, “The breadth of its research, policy and development work reflects the needs of rural and remote communities to improve critical problems of health, wellbeing and service delivery.

“Key issues addressed by the ARHRC include mental health service delivery, maternity, avoidable hospital admissions, palliative care, farm safety and Aboriginal health.”

The ARHRC is a combination of rurally based academic centres from The University of Sydney and the University of Newcastle working in partnership with NSW Health, Local Health Districts, Primary Health Networks and the Royal Flying Doctor Service.

Such centres help to grow the intellectual capital and resources of regions, providing leadership, building critical mass in health research and supporting implementation of evidence based practice.

The ARHRC’s 2015 Annual Report is available at:

http://sydney.edu.au/medicine/research/rural-health/arhrc/annual-reports.php

Paradoxical HILDA says rural kids healthier

Contrary to the perceived wisdom that regional/rural dwellers are generally less healthy than their urban counterparts, the latest survey of Australian households says children in non-urban areas are reportedly healthier than their city cousins, with the latter group undertaking a greater number of GP visits.

Another reported paradox is that activity levels are positively associated with relatively high alcohol consumption (15-42 drinks per week) for males, and moderate alcohol consumption (11-14 drinks per week) for females. Further, being a smoker is not associated with any effects on activity levels for females, while for males it is - “surprisingly”, as the survey observed - associated with a higher activity level than that of non-smokers.

The 11th Household, Income and Labour Dynamics in Australia (HILDA) Survey was authored by Prof Roger Wilkins from The University

of Melbourne’s Melbourne Institute of Applied Economic and Social Research, and funded by the Australian Government Department of Social Services.

The survey also found that non-urban children are less likely to be admitted to hospital than city kids, and are “considerably more likely” to have seen a dentist in the last two years.

However, it appears that a truer divide may relate to the socio-economic status of residential areas, as living in a more advantaged place appears to be associated with better reported health and fewer GP visits.

The HILDA Survey annually collects information on a wide range of aspects of life in Australia, including household and family relationships, child care, employment, education, income, expenditure, health and wellbeing, attitudes and values on a variety of subjects, and various life events and experiences.

Information is also collected at less frequent intervals on various topics, including household wealth, fertility related behaviour and plans, relationships with non-resident family members and non-resident partners, health care utilisation, eating habits, cognitive functioning and retirement.

The important distinguishing feature of HILDA is that the same households and individuals are interviewed every year, enabling insight to how their lives are changing over time.

Our Way Stories

Published by Arts Northern Rivers, which funded production through donations from local residents and trusts, Our Way Stories in a beautifully illustrated collection of life stories recounted by ten Bundjalung Elders from this area.

Collected by Dale Simone Roberts over a two-year period, these oral histories are a valuable legacy of times past but not forgotten, and a reminder that here, like elsewhere in Australia, Indigenous people have survived despite terrible odds: "There were a lot of massacres... White fellas killing black fellas", says Aunty Gwen Williams about the early days in Evans Head.

The book was launched at a packed event at the Byron Writers Festival on 5 August, with the Elders sharing music and songs, and speaking of their experiences growing up in and around the Northern Rivers towns.

"All of the Elders have embraced the project understanding that it is a unique opportunity to have their lives recorded in their own words and to pass on their knowledge before the stories are lost," Dale writes in the introduction.

Aunty Marie Delbridge holding photo from book "Our Way Stories". photo: Kate Holmes

Uncle Magpie from book Our Way Stories Photo Kate Holmes

Language lies at the heart of the project, and as Elders noted at the launch, they were forbidden from speaking Bundjalung, in which they had been raised, when interacting with mainstream society.

Aunty Marge Close recalls that, "Granny took charge of us, they spoke lingo, they all talked the lingo, I could understand. All the old people spoke it. When we were at school we had to talk English."

In one of the book's historical photos, Aunty Dorrie Gordon, the first Aboriginal woman in NSW to become a Minister, is shown being daubed with ochre face paint prior to her ordination. The Elders in the Grafton area wanted her to remember her culture and "not forget it because I was going on to a bigger, higher thing in my life."

The archival images complement the

superb portrait and location photography by Kate Holmes, with Zoe Robinson-Kennedy's design making the large-format, glossy paperback a truly lovely work.

The frequent cultural reminiscences remind us of how Aboriginal people - not only the Elders - continue to regard culture as central to their lives.

Pop Harry Walker, born "at the side of the big bridge in Tabulam", recalls taking part in the corroboree called Yoward, enjoying how he "loved to see the painted bodies... the sound of the didgeridoo and the clap sticks... growing up as a young boy, listening was very important, for to learn was to listen, and to listen was to learn."

Aunty Viv Laurie King, Byron Writers Festival. Photo : Kate Holmes.

His use of present tense highlights how culture is still alive: "It makes us happy, it brings joy to our souls, it makes us rejoice in the land knowing we are the people of the land."

This project does great justice to the people of Bundjalung country, and the good news is that a follow-up volume is being planned - crowd-funders get ready!

At the Byron Writers Festival launch were (l-r) Uncle Mickey Ryan, Uncle Magpie, Aunty Marie Delbridge, and Aunty Dorrie Gordon. Photo: Kate Holmes.

Uncle Athol Compton Photo: Kate Holmes from Our Way Stories book.

The project partner for Our Way Stories was Bulgarr Ngaru Medical Aboriginal Corporation. Platinum supporters were the appropriately named Elders Real Estate offices in Bangalow and Lennox Head. Bronze supporters were Jan Barham, Dr Andrew Binns, Stephanie Boldeman and North Coast Community Housing. In addition, more than 150 individuals supported the project through crowd-funding donations.

An international scientific, medical, allied health and health policy multidisciplinary and CPD event.

Lifestyle Medicine 2016 AUSTRALASIA

FRIDAY 4 - SUNDAY 6 NOVEMBER 2016
MELBOURNE, AUSTRALIA

Themes
- 'Diabesity', metabolic & cardiovascular diseases
- Depression, mood & anxiety disorders
- The microbiome in mental health & chronic disease
- Personalised medicine: clinical applications of the 'omics'
- Coaching to change lives: facilitating health behaviour change
- Shared Medical Appointments: a quantum leap in chronic disease management

Streams
- Clinical (practical 'how to' focus)
- Scientific (oral abstracts & posters)
- Policy (world experts & think tank)

Who should attend
GPs & MEDICAL SPECIALISTS
DENTAL PRACTITIONERS
PUBLIC HEALTH PHYSICIANS
HEALTH POLICY PROFESSIONALS
SCIENTISTS & RESEARCHERS
ACADEMICS & EDUCATORS
DIETITIANS & NUTRITIONISTS
NATUROPATHS
EXERCISE PHYSIOLOGISTS
PSYCHOLOGISTS
NURSES & PRACTICE NURSES
DIABETES EDUCATORS
SOCIAL WORKERS
COUNSELLORS
PSYCHOTHERAPISTS
OSTEOPATHS
PHYSIOTHERAPISTS
CHIROPRACTORS
PHARMACISTS & ASSISTANTS
OCCUPATIONAL THERAPISTS
OTHER ALLIED HEALTH

RACGP Cat1 QI&CPD and other CPD points pending application

EARLY BIRD DISCOUNT ENDS SOON

SEE THE CALL FOR ORAL & POSTER ABSTRACTS & STUDENT SCHOLARSHIPS

Offering evidence-based knowledge, skills, tools and procedures for clinicians though participatory workshops with case studies and discussion, the latest translational scientific research from around the world, a deep exploration of determinants and systemic issues for health policy professionals, and an 'Innovation & Enterprise' future think tank and consensus statement to be released to local and international media.

American College of Lifestyle Medicine
Australasian Society of Lifestyle Medicine
EUROPEAN LIFESTYLE MEDICINE ORGANIZATION

www.lifestylemedicine.org.au

UCRH sees the biggest intake of Medical Students

With the latest group of students arriving in the Northern Rivers to undertake placements at local GP practices and hospitals, the program run by the University Centre for Rural Health/North Coast is proving its appeal to undergrads from metropolitan universities.

UOW students Hi to Bye skills

During stays ranging from 4 to 18 weeks, the 39 students will gain a good understanding of what it means to practice medicine in the community, and the importance of the relationship between patients and their family doctor.

The students are from Western Sydney University, University of Newcastle and University of Wollongong. They join the current group pf 16 'long-stay' students from the University of Sydney, who spend a year in the latter phase of their studies.

The UCRH has educational campuses in Lismore, Murwillumbah and Grafton. It is committed to addressing rural health workforce shortages, and these placement programs play an important role in this.

UNIVERSITY CENTRE FOR RURAL HEALTH
NORTH COAST
education research workforce

WSU student complete scrub competencies and skills

Following graduation many UCRH students return to the region as hospital interns and/or GP Registrars, bringing with them the skills and experience they have gained.

The role of the supervising clinician and the support teams is pivotal, while patient responses to medical students in the practices have been overwhelmingly positive.

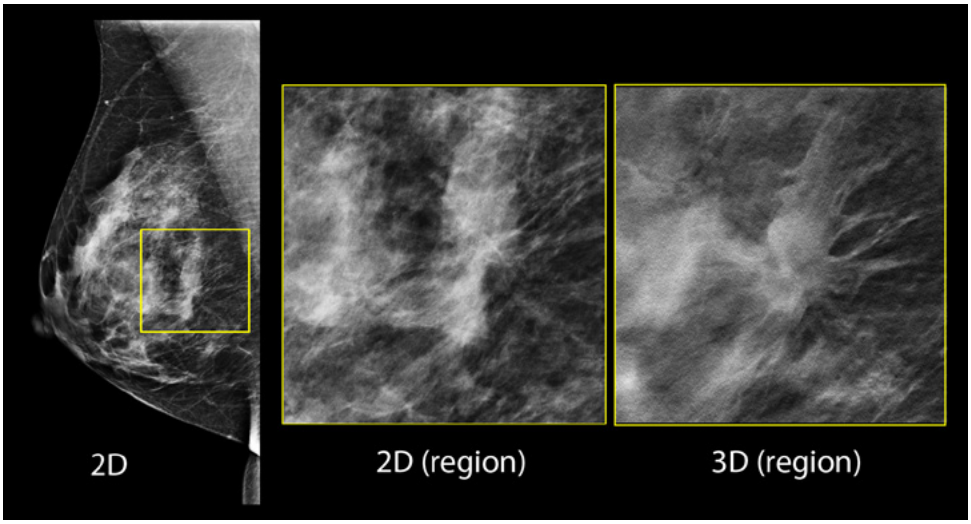
UNIVERSITY OF WOLLONGONG AUSTRALIA

Bangalow Medical Centre nurse Donna with UOW student Danielle

A collaboration between The University of Sydney, University of Western Sydney, University of Wollongong and Southern Cross University supported by the Australian Government Department of Health and the Northern NSW Local Health District

GENIUS 3D™ MAMMOGRAPHY

Research shows a significant improvement in early detection rates and a reduction in the number of women who are unnecessarily recalled for further testing.



North Coast Radiology Group will offer Genius™ 3D MAMMOGRAPHY™ exams to women living in the Northern Rivers Region from 6th Sept 2016. This newer technology produces a three-dimensional view of breast tissue and has been shown in clinical studies to be significantly superior to traditional 2D mammograms.

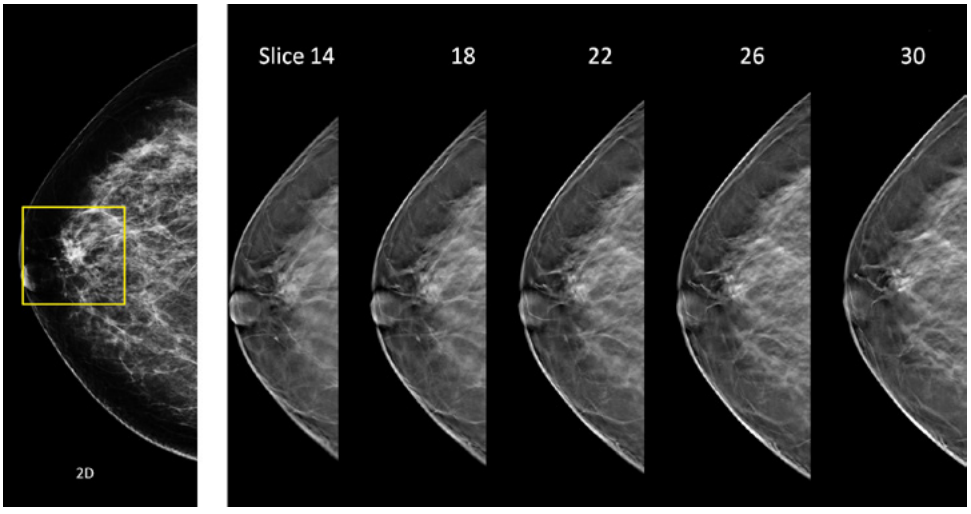
3D Mammography with Tomosynthesis enables radiologists to identify and characterise individual breast structures without the confusion of overlapping tissue, which can result in false positive findings with traditional 2D mammography. This means more women will be spared the anxiety of being called back for further testing with a Genius 3D MAMMOGRAPHY™ exam.

Donna Riley, Modality Leader for X-ray, BD and Mammography and Radiation Safety Officer says
"The new Genius 3D Mammography system only takes a few seconds longer than a standard 2D Mammogram and the compression used is the same as for a 2D Mammogram. This ensures that we receive a more accurate and detailed examination with no increase to patient discomfort."

Dr Warren Lun, Women's Imaging Specialist Radiologist at North Coast Radiology says "We expect that digital mammography and tomosynthesis will allow earlier detection of smaller cancers, with less frequent misleading findings from overlying normal breast tissue. This should benefit all patients but will be especially valuable for women having diagnostic mammography such as those with a strong family history, patients with breast changes or symptoms, as well as younger women with dense breast tissue."

For more information about this new service, contact Helen Spurgeon on either 66236131 or 0488 126 819

For women having a Genius 3D MAMMOGRAPHY™ exam, the experience is very similar to a traditional mammogram. During a 3D MAMMOGRAPHY™ exam, the X-ray arm sweeps in a slight arc over the breast, taking a series of images at various angles in just seconds. The technology then produces a series of very thin layers or 'slices', typically around 1mm thick, allowing Radiologists to view a 3D reconstruction of the breast.



Inflexible systems used by GP Synergy

Opinion

According to its website, GP Synergy is "the sole provider of the federally funded Australian General Practice Training (AGPT) program for doctors seeking to specialise as General Practitioners (GPs) in NSW and ACT." It offers, they add, "a diverse range of high quality education and training opportunities across rural, remote, outer-metropolitan and metropolitan settings."

GP Synergy was awarded the contract to manage GP training in northern NSW (and other areas) from 1 January 2016. Its initial activity was discussed by Northern Rivers GP Dr Ruth Tinker in the Autumn issue of GP Speak this year. Here, Dr Tinker follows up on how the organisation is managing the transition from its predecessor, North Coast GP Training.

GP Synergy has not worked through how to best support supervisors of part time GP trainees.

In our practice, for example, there are two part time GPT1s. One works two days a week and has done all year. The practice will receive less support funding in semester 2 for that registrar to do the same hours on the same days for an extra week (semester 2 is 27 weeks, semester 1 was 26).We will be doing the same work for an extra week for less.

I understand it is something to do with a change of definition of full-time hours, making the same number of hours a smaller proportion of full-time, hence the payment is reduced as a proportion of full-time.

Our second part-time registrar is shared between two practices. The practice will have that registrar for three days, and another practice for two days. The practice support payment is split pro rata (approx one third - two thirds) but the teaching funding has to be divided 50/50. Given that much of the teaching is done around real patient consultations, this does not reflect reality. This view is shared with the other practice, by the way.

GP Synergy can and will split one payment pro rata, but it seems unable to split the other the same way. Any adjustments have to be arranged between the two practices. I am not sure of the implications of one practice passing some of their payment to another.It feels like another blow for trainees who need to train less than full-time. In addition to the practice issues of scheduling part-time sessions, there is now also a financial disincentive.

In spite of the fact that at the end of semester 1 the registrar has completed a little over 10 full time equivalent (FTE)weeks, we are required to complete the same number of assessments as if the registrar worked full time. So by the time the registrar has completed 26 FTE weeks, they will have been assessed more than twice as often as a full-time trainee. This is wasteful of supervisor time and energy. The Competence Grid takes me 40 minutes each time, and as already stated we are getting a fraction of the FTE funding.

Another concern is about Synergy's regional advisory committees.

These are appointed, with no input about the members constituting the committee, from those on the ground. There is a rep from the supervisor association, but there are also reps from Local Health Districts, from RFDS, and university reps. (I am still at a loss to see the relevance of city-based universities to rural postgraduate community based GP training). Nevertheless, a sensible recommendation that Tweed Heads should be considered a more urban area for training purposes was refused on the grounds that it would cause administrative issues with trainee placements.

So one could spend two years in a suburban practice in Tweed Heads and be deemed to have trained for two years in a rural setting like Maclean. While trainees who work in large rural towns such as Lismore and Port Macquarie have to spend six months somewhere more rural or disadvantaged - and that could be Tweed Heads!

Apart from my issues with the make-up of the committee, it seems GP Synergy will ignore advice that doesn't suit them. I know they were given a much larger job than even they seemed to have expected. I believe that unless they are prepared to adapt, and take advice from those at the frontline, there are genuine grounds to fear for the future of our registrar training system.

Dr Ruth Tinker

LETTERS TO THE EDITOR

Dear Editor

Re "Wellness for Medical Students" page 5 Winter/2016 edition

You're kidding.

I can't get timely endoscopy or surgery for my patients.

I can't get up to date vaccines for my poor patients, eg meningococcal B.

And you're spending the taxation dollar teaching medical students to hula hoop??

Yours faithfully

Dr C. R. Theodore M.B.B.S.

Dr Jane Barker replies:

Hula hooping was simply a small part of a fun team-building exercise aimed at providing our students with tools to cope better with exactly the kind of frustrations you describe - which they are bound to deal with during a career in medicine.

On a more serious note, beyond-blue describes alarming numbers of medical students who are already showing signs of cynicism, burnout and mood disorders even before they qualify.

Training medical students is indeed a very expensive exercise, much of it achieved by relying on the goodwill of physician teachers.

Preventing future workforce loss through mental health issues should be integral to this training. Hula hooping is quite mindful - you should try it!

Book Reviews

Mirroring the demographics of our society, books about ageing, end-of-life-care and death have become increasingly frequent and these works from two well-regarded Australian authors are valuable additions to the burgeoning field.*

Both are well written, brimming with empathy for their subjects, and sharply analytical about the barriers and prejudices faced by Australians as we age.

While commenting on covers may be superficial, I would note the coincidence of both depicting butterflies - do they signify old age, and if so, how? - although in the case of the Kaminsky book an heirloom butterfly brooch makes an appearance.

Dr Kaminsky, a GP, observes that, "During thirty years of practice you get to see a wide range of ailments, a veritable litany of woes. Always at the back of my mind has been a rumbling sense of dread, loosely disguised by a morbid curiosity to know where and when I am going to die.

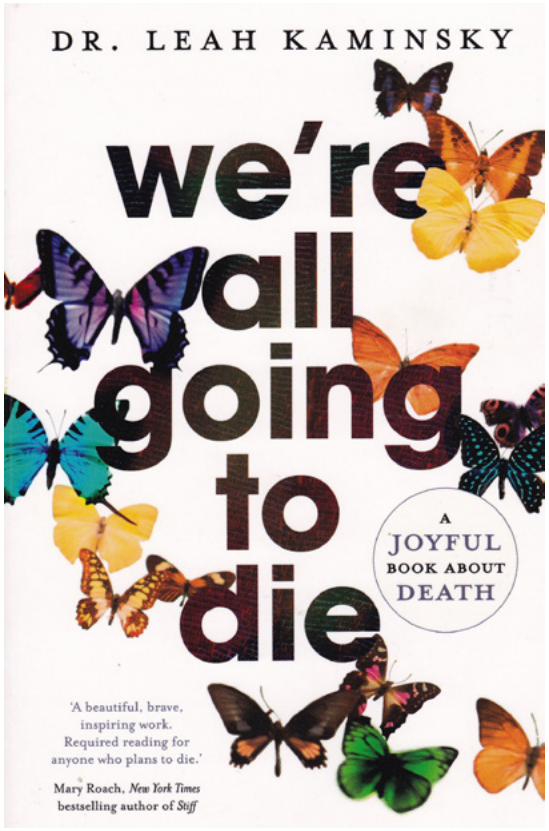
"Which disease number will come up? Until now, it's all been a bit of a crapshoot trying to predict, and hence prevent, whatever disease might have my name written on it."

While contemplating her own mortality, she recognises that while "we all have to die one day... if we strive to surround ourselves with life and meaning, we only have to die once."

In the meantime, then, we should seek the best life possible, a philosophy highlighted by the story of 90-year-old Julia, a patient with a multiplicity of conditions who seeks medical approval to contest a 50-metre swim in the over-75s class at the Senior Olympics.

Fearing an adverse outcome, Kaminsky hesitates, but after a checkup gives the go-ahead.

"Maybe I was worried that her family might sue me if something went wrong, or perhaps I was simply being ageist."



Some time later, Julia returns, proudly waving a gold medal from the event. As it turned out, she was the only one in the race.

Kaminsky cites psychiatrist and Holocaust survivor Victor Frankl who said we can only make peace with our mortality by finding meaning in our own lives.

As the author puts it, "Rather than dreaming of having better sex, bungee jumping off a cliff or meeting Elton John, living a life in which we are true to ourselves is far more rewarding than merely walking along the treadmill of existence."

Focus subjects include end-of-life directives, the pathological fear of childbirth, and the importance of

those working with the dead, truly "the oldest profession in the world."

The long road to death in various social and cultural contexts is the focus of the eight 'essays on old age' by Melanie Joosten whose acclaimed novel Berlin Syndrome is now being made as a film.

With a masters in social work, she is accustomed to meeting older people, and focused her interviews for this book more on the present and future than the past, discovering that "a failure of our bodies and their constituent parts is only the most obvious facet of getting older."

Less obvious but more concerning, she writes, is how society "orchestrates our gradual exit from public life as we age, recasting us from lead players with individual agency to burdensome detritus."

This book also pulls no punches, making it another valuable contribution to the debate we need to have.

She continues, "Too often the only public conversation about ageing revolves around the question of euthanasia, discounting the possibility that as we as a society figure out how to live our later lives with dignity, perhaps we are in no position to jump to conclusions about how to end our lives with dignity."

Addressing the current 'positive-ageing agenda', Joosten worries about the expectation that all older people should be fit and healthy, and positively engaged with life, with an inability to do so being often framed as a personal failure - not all nonagenarians can swim competitively!

This pressure, bolstered by superannuation ads and health promotion materials, ignores not only wider systemic causes but the fact that some things, such as the inevitability of death, cannot be treated or cured.

Yet this agenda "posits that a person's best self is their young self - before the onset of any age-related concerns - and sees old age as a corruption of the natural way of things rather than a continuation."

Equally concerning is that with almost two-thirds of over-85s being female, does the treatment of older people as "second-class citizens" result from their being mainly women?

Many questions are raised in this thoughtful work by a writer whose social work commitment arose from "a feeling of obligation towards those who do not have the opportunities I have had."

The answers may be obvious but are proving hard to achieve: we need better end-of-life dignity, ideally at home, and a greatly enhanced aged-care and services environment, which she dubs "the biggest challenge of our ageing population".

Mirroring Kaminsky, Joosten emphasizes the importance of living the most meaningful life while this is still possible.

"How we feel about leaving this world is influenced by how we live in this world - even as we are dying... we must properly consider the needs of our ageing population both as individuals and as a cohort, to discourage the presumption of burden and to embrace the ever-changing nature of a long life."

Both books are valuable contributions to this ongoing discussion.

*The same trend is apparent in other developed countries, with one forthcoming title of note being Aging Wisely by contemporary philosopher Martha Nussbaum and Harvard law colleague Saul Levmore.

According to The New Yorker http://nyer.cm/KnCWbm1 the pair investigates the 'unknown country' of old age, examining the moral, legal, and economic dilemmas: "The book is structured as a dialogue between two aging scholars, analyzing the way that old age affects love, friendship, inequality, and the ability to cede control.

"They both reject the idea that getting old is a form of renunciation.

"Nussbaum critiques the tendency in literature to "assign a 'comeuppance' " to aging women who fail to display proper levels of resignation and shame. She calls for an "informal social movement akin to the feminist Our Bodies movement: a movement against self-disgust" for the aging.

"She promotes Walt Whitman's "anti-disgust" world view, his celebration of the "lung-sponges, the stomach-sac, the bowels sweet and clean. . . . The thin red jellies within you or within me. . . . O I say these are not the parts and poems of the body only, but of the soul."