GPSpeak

On the road to wellbeing -
how exercise helps combat disease

- **Home visits - money wasted?**
- **Travel - GPs in China and Costa Rica**
- **Osteoarthritis management**

North Coast Health Matters

Spring 2017

GPSpeak

Published by:
Northern Rivers General Practice Network
PO Box 106, Lismore, NSW 2480
info@nrgpn.org.au
www.gpspeak.org.au

INSIDE THIS ISSUE

GPSPEAK ON THE WEB

www.gpspeak.org.au

SEARCH

GPSpeak is available in pdf and Issuu format from our website. **Article references are available via the online hot links.**

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

And don't tell me what to do
Don't tell me what to say
And please, when I go round with you
Don't put me on display 'cause

You don't own me
Don't try to change me in any way
You don't own me
Don't tie me down 'cause I'd never stay

You Don't Own Me 1963, Lesley Gore

The Social Services Legislation Amendment (No Jab, No Pay) Bill of 2015 has brought about an increase in childhood vaccination rates around the country and also on the North Coast. The essence of the Amendment was to remove conscientious objection to vaccination as an exemption from the requirement of children to be fully age appropriate vaccinated to be eligible for child care subsidies and Family Tax Benefit A.

Vaccination rates have risen to 93% nationally and are approaching the 95% level recommended for herd immunity. All Primary Health Networks (PHNs) reported rates of greater than 90%. However, rates can vary widely within PHNs and in this issue we report (page 8) on the 1867 North Coast kids who are unimmunised. Recent Department of Health Data have shown shown that less than 50% of Mullumbimby two year olds are fully vaccinated; the lowest in the country.

To improve the levels and to counter last year's anti-vaccination film, Vaxxed: From Cover-Up to Catastrophe, the Department of Health has launched a 5.5 million dollar campaign targeting areas of low vaccination.

Most North Coast general practitioners will have experienced long consultations with a parent debating the risks and benefits of vaccination for their child. Thankfully, these are less frequent now the conscientious objection exemption has been removed. Teasing out the science and the pseudo-science in these encounters is a long, labour intensive and often futile activity and not viable in a busy general practice.

As Dr Tony Lembke has recently noted on Radio National we must help our patients understand the full ramifications of their decisions. There has been some recent discussion about how best to achieve this.

Personal stories cut through. Older GPs may recall North Coast cases of the relatively common complication, Dawson's encephalitis, the progressive neurological deterioration and early death from infantile measles.

Measles is rare now but has not been eradicated from Australia as once claimed. However, whooping cough remains very prevalent locally. Toni and David McCaffery of Lennox Head, parents of Dana who died in 2009 at the age of one from this disease, graciously appear in one of the Department of Health videos.

Telling an anti-vaxxer that their views are wrong has been shown to be counter-productive and, in fact, is more likely to strengthen their views. Recent research has suggested that highlighting the dangers of childhood infections is more effective than debating vaccination adverse reactions.

As GPs, we need to make our patients aware that the risks are high for all those unvaccinated children living in the viral culture medium of the North Coast hinterland.

Australians have some of the highest out-of-pocket medical expenses in the OECD, surpassed only by Switzerland. Some 12 per cent of Australians' health expenditure comes out of the patient's pocket, with dental care, private hospital charges and medical specialist fees making up the bulk of the expenditure.

Although private health insurance can go some way to covering such costs, out-of-pocket expenses can still be quite significant, and vary depending on a patient's location – witness the recent media coverage of disparate fees charged by surgeons for the same procedures.

Moreover, despite having paid for private cover, large, additional out-of-pocket costs for specialist in-hospital treatment cause some patients to opt for public hospital care.

The public hospital system is not averse to taking private patients. Charging health funds for in-patient treatment is deemed a much needed source of income by public health administrators. Similarly, getting GP referrals for outpatient specialist services brings in further revenue. The reason for the cost shifting from the State to the Commonwealth for self limited conditions escapes most patients and annoys them and GPs alike.

Private health insurers are placing restrictions on the services they provide and increasing their flag fall charges for each item of care. It is reported that private hospitals are feeling the pinch.

The current government is very keen on market forces in all aspects of Australian economic life, including medicine. Currently the Senate Community Affairs References Committee is reviewing the Value and Affordability Of Private Health Insurance And Out Of Pocket Medical Costs. It is due to report on 27 November, 2017.

Some are campaigning for an increased transparency in medical costs so that market forces can be brought to bear. The government has nearly all the required information to do this from the Medicare data it already holds, and it is not beyond the realms of possibility that it could publish a "Doctors' Fees Watch" website. However, this may prove more difficult than anticipated, given the history from 2008 of Kevin Rudd's ill-fated Grocery Watch website.

It has also been suggested that a Medicare rebate be denied when the fee charged exceeds that recommended by the AMA. This seems somewhat fanciful given it would be directly counter to a free market philosophy. It may also be determined that the regulation of fees is unconstitutional. We shall await the Senate Committee's report.

Nationally the rates of bulk billing are much higher for general practitioners than for specialists and the rate has stayed fairly constant, much to the chagrin of the Treasurer, despite four years of the Medicare freeze.

This issue of GPSpeak (page 23) reports on a study done locally on the availability of North Coast general practices to provide a same day appointment for a new patient. The study found just under half of North Coast practices could accommodate the patient that day, that bulk billing was only available in 20 per cent of practices and the mean out-of-pocket costs were close to $30.00.

The study, approved by the Southern Cross University Human Research Ethics Committee and the North Coast Primary Health Network, used a secret shopper methodology. The researcher posed as a relative of a 60 year old

cont on P4

Editorial

cont from P3

woman, new to the North Coast, suffering abdominal pain. The data sought by the study was whether the patient could get a same day appointment, preferably with a female GP and have the consultation bulk billed. If bulk billing was not available, the out-of-pocket costs were sought.

It's hard to know what GPs will make of this study. The implication that they should do more for less will be very familiar but any change will have to come at the national level and given the current environment this is unlikely.

Following last issue's report on the mental health issues facing doctors, Tweed Heads anaesthetist, Dr Ian McPhee details some of his experiences as a health professional suffering from depression (page 7). He also reports on his and others' work in advocating against mandatory reporting of mental health issues. GP*Speak* congratulates him on his efforts in helping bring about the recent move by the Health Ministers of the Council Of Australian Governments to reverse mandatory reporting.

On page 12 Dr Ric Milner also gives a personal account of his experiences, this time in prostate cancer. Ric focuses on the role of exercise in advanced cancer and on page 9 he reviews the studies of the various aspects of exercise in cancer patients. While noting it is not a cure, he advocates strongly for its role in improving this last stage of one's life journey.

Exercise also seems to be useful in making our back, hips and knees last a little longer. Professor David Hunter, rheumatologist from the Department of Medicine, Sydney University argues for a biopsychosocial approach to chronic arthritic pain and has recommendations for GPs to consider other treatments somewhere between the pills and the knife.

Join a club, make new friends and explore the world. Those with a little cartilage left in their knees may be inspired by Dr Kim Kerr's recent trip with a Northern Rivers group to China to run the Great Wall Marathon (page 11).

Following a government directive, the North Coast Primary Health Network ceased to be a support organisation for primary health practitioners on 1 July 2016. The current focus is on commissioning, integration and primary healthcare quality. Working in partnership with the Northern New South Wales Local Health District there has been steady progress in a number of areas.

While far from perfect the last 12 months has seen improvements in the timeliness and quality of discharge summaries. In particular, the efforts of the Mental Health Unit should be acknowledged in this area.

Equally there has been an improvement in the quality of general practitioners' Shared Health Summaries, partly brought about by the My Health Record financial incentives. The summaries are increasingly sought, and hopefully used, by the Emergency Departments and outpatient clinics.

Preoperative blood management has made significant progress in the Northern Rivers over the last two years and the Northern Rivers General Practice Network congratulates the NNSW LHD on what has been achieved and appreciates their ongoing support in providing in-house training for practices contemplating surgery based intravenous iron transfusion (page 27).

Innovation is not easy and there are many missteps along the way. The work being done on the Medical Home and the Winter Strategy is to be supported and the learnings from the mistakes will shape the future direction.

Communication is the key and despite the technical problems, information technology will drive improvements in our healthcare system. Adding pathology and later radiology to the My Health Record will bring both advantages and challenges to be managed. Changes in this area along with the electronic reporting of BreastScreen data (page 24) are expected in the next two years.

In p4$$Word (page 30) we offer some advice on staying safe in this electronic world. Security can be a hassle but nothing is worse than a system compromised and held to ransom.

It looks like the future is bright for innovators and those trying to make the North Coast medical world a little better. If we to tap into the zeitgeist, we might say, "blessed are the fruitful, the geek and the #woke".

After-hours doctor visits under scrutiny

by Robin Osborne

The rising demand for costly after-hours home visits by medical practitioners is impacting negatively on the federal health budget and attracting criticism from various quarters, including the Australian Medical Association.

The increase in Medicare payments for the two main categories of after-hours home visits are now the subject of close examination by the government's clinician-led Medicare Benefits Schedule Review Taskforce, which in its recent interim report made several key recommendations, including:

- Restricting the use of the high value urgent after-hours items so that medical deputising service doctors and practitioners working predominantly in the after-hours period are excluded from billing these items
- Providing a clearer definition of what is considered to be urgent for the purposes of the MBS urgent after-hours items, including changing the requirement to 'urgent assessment' as opposed to 'urgent treatment'
- Removing the current right of patients to make an urgent after-hours appointment two hours before the commencement of the after-hours period.

Figures show the amount paid on after-hours items grew by 170 per cent between 2010-11 and 2015-16, from $90.8 million to $245.9 million.

After-hours home visit figures* accessed by GP*Speak* reveal exceptionally high usage in the Coffs Harbour area, where in 2015-16 (the latest available data period) total billing was almost $2.0 million, with demand trebling from the previous year.

Urgent after-hours visits are covered by two MBS categories, Item 597 'Urgent attendance after-hours (7am-8am & 6pm-11pm)', which attracts a fee of $129.80, and MBS Item 599 'Urgent attendance unsociable after-hours (11pm-7am)', where the fee per patient is $153.00.

Non-urgent after hours home visits range from $54.95 to $143.70. Both categories are higher than in-hours home visits, and significantly more than practice consultations.

Between 2012-13 and 2015-16 Coffs Harbour's demand soared from 276 Item 597 visits to 13,633, and eight Item 599s to 1411.

'Doctor and his patient' - Jan Steen [Public domain], via Wikimedia Commons

The general trend in other North Coast regions was mixed, but largely upwards, although the scale was much less. Richmond Valley Hinterland callouts totalled 197 for both Items, a rise of around 50%, while Richmond Valley Coastal went against its previously rising trend to record 588, a drop of around 20%. The Clarence Valley's 294 home visits for Item 597 consultations was twice the previous year's.

Tweed Valley recorded low demand for home visits, with only 42 in Item 597 and none in Item 599.

At the bottom end of the coast, Port Macquarie accounted for 973 urgent attendances, and a further 65 late night urgent callouts, for a total MBS cost of $126,295.

The Taskforce is considering the issue as part of its broader review of Medicare items, following concerns that after-hours costs were increasing far in excess of population growth.

"The growth in provision of after-hours services... has coincided with the entry of new businesses into the market..." - MBS Review Taskforce

The AMA has said that, "direct marketing and the promotion of after-hours home visiting services as being free and easy to access is driving much of this growth, as opposed to genuine patient need."

In recent times such names as National Home Doctor Service and Dial-a-Doctor have become well known for offering after-hours services on behalf of GP practices, including those in regional areas.

The response from the industry body, National Association for Medical Deputising Services, was that these services save the health system more than they cost, because many of the patients would otherwise go to emergency departments, which are vastly more expensive.

It claimed that the changes would result in "rolling closures of services in regional communities and cost lives".

However, the Taskforce believes the current structure of urgent after-hours items provides low-value care and is not convinced the growth in home visits had significant reduced demand on hospital EDs.

"The current use of urgent after-hours services does not reflect clinical need in Australia..." - Taskforce chair Prof Bruce Robinson

"The growth in provision of after-hours services appears not to be driven by increasing clinical need for these services, but has coincided with the entry of new businesses into the market with models that promote these services to consumers, emphasising convenience and no out-of-pocket costs," the interim report said.

"Many urgent after-hours services claimed as urgent are not truly urgent, as intended when the items were created, and the distinction between 'urgent' and 'non-urgent ' appears not to be well understood by many medical practitioners."

It recommended the rebate should only be payable when a GP who normally works during the day is recalled to manage a patient who needs urgent assistance.

'Urgent' would refer to an assessment that cannot be delayed until the next in-hours period and would require doctors to visit the patient or reopen their rooms.

Taskforce chairman Professor Bruce Robinson said, "The medical community recognises the need to remove MBS fund-

cont on P6

After-hours scrutinised

continued from P5

Dr Michael Gannon and Professor Bruce Robinson

ing from unnecessary, outdated, ineffective and potentially unsafe services. It was the strong view of the Urgent After-hours Working Group and the Taskforce that the current use of urgent after-hours services does not reflect clinical need in Australia.

"The growth in use of urgent after-hours GP services does not seem to reflect patients' clinical needs.

"After-hours services are important, but we must ensure that patients get the right test or treatment first time, every time and not be subjected to unnecessary and inappropriate care."

For its part, the AMA supports after-hours reform for various reasons, including:

- The significant growth in the use of after-hours Medicare items, particularly the use of urgent after-hours items, and the detrimental impact this is having on the link between patients and their usual GP or general practice;
- concern that direct marketing and the promotion of after-hours home visiting services as being free and easy to access is driving much of this growth, as opposed to genuine patient need; and
- poor communication from some after-hours medical services to a patient's usual GP or general practice – resulting in the fragmentation of care.

AMA President, Dr Michael Gannon, said, "Our focus will be on the Taskforce's final after-hours report - which will be released later this year after the Taskforce has considered stakeholder feedback - and the Government response to the final report.

"If the final report and subsequent Government after-hours policy lead to MBS savings, they must be re-invested back into general practice."

Reference: Department of Health, 2016. Medicare Benefits Schedule Data: MBS Data by ABS SA3.

Medicine must stop eating its young

by Dr Ian McPhee

The medical profession is best placed to help colleagues encountering mental health issues, writes Dr Ian McPhee, a self-confessed 'black dog' sufferer.

Dr Ian McPhee

In recent times there has been a broad, very public focus brought to the matter of doctors' mental health. Not at all unreasonably, it is the plight of hospital-based, junior doctors that has captured the bulk of attention. Something has happened to make JMO life even more stressful. It isn't just the long hours - we all endured those - nor is it exam pressures, likewise experienced by everyone.

Medicine, as much as it might be the same in so many respects, has begun eating its young.

But wait, I hear you say, there was that surgeon I knew, that GP, the gasman.... didn't they succumb, either with their careers or lives?

And sure enough, the stories are legion, along with data stretching back decades that shows a life in medicine carries risks of mental illness at rates higher than most professions, and significantly higher than the general population.

Within our profession, however, it has remained a dirty little secret. Obituaries in the press, and even our respective College magazines and journals have, until very recently, been long on praise for a life at the coalface, and so sadly short on facts relating to suicide when it has been the cause of death.

For some of us, when personal experience grants insight and a sense of knowing, what has not been said has moved us more than the detail might have.

But what of others? Why are we so reticent to tell it like it is, to shroud an end of life story in euphemism? In answer I have nothing other than a plea for this to change.

My own adult years have been spent always with the black dog lurking ominously. Kept in check for the decades until my forties, I struggled through, bouncing back from an occasional mauling with the assistance of loved ones and, when I could manage it, a holiday. This was just the way it was, I told myself repeatedly. After all, as a student, when I had thought things were tougher than they should have been, it is what I was told when I had gingerly approached liaison psych in the teaching hospital I was in.

The fall though was inevitable. There's only so much 'resilience' - a term I use circumspectly - an individual has, and, up to my eyeballs in an incredibly demanding post, it came.

But what to do when this happened? And why had I allowed it?

To answer the first question requires a little scene setting. I was a freshly minted consultant in a provincial centre. I had no GP. I wasn't even that sure what was going on. I was defeated and frightened. I had no close colleagues and there were some who resented my very presence in the town - did someone say 'turf war'?

Ultimately for me, assistance came down to a phone call. If everything else might have failed someone even today, that same option remains available - the Doctors Health Advisory Service continues to fulfil a special role. Importantly, assistance is prompt, focused, and delivered by individuals with a commitment to supporting their colleagues.

Of course, intervention before a 'fall' would be so much more appropriate. But why is it that this is still not the norm? What are the factors that drive mental ill health on the one hand, and discourage timely help seeking on the other? Is it that we 'allow' this to happen as I had earlier suggested?

And so to 'resilience'. How easy it has been for doctors to have been labeled at fault - not cut out for the job, bereft of necessary coping skills, failing to care for themselves, or, even more desperately, simply regarded as collateral damage by a system denying responsibility.

The mainstream literature is now full of references decrying the ease with which blame has been levelled at the individual.

This from the BMJ of 27 July:

'.... a focus on individual resilience can shift responsibility for burnout* away from systems and not tackle the root causes...'

I won't explore the burnout/depression conundrum. It is however well reviewed here.

Solutions ultimately lie elsewhere. From that same BMJ piece:

'..... professional bodies and healthcare organisations must consider the improvement of doctors' wellbeing and working lives as central to patient care. While individually targeted interventions can make a small difference, only a concerted, system level approach will deal with system level causes.'

Jane Barker's thoughtful contribution to local discussion of support for JMOs, in the last edition of GP*Speak*, explored some of the options for system level responses.

My take is that any such responses should acknowledge and embrace equally the needs of senior clinicians. The story, so poignantly and bravely put by his family, of the suicide of Brisbane gastroenterologist, Andrew Bryant, bears this out.

It simply has to be that, in language that is clear and understood by everyone, we can all tell our stories without fear of stigma, or worse, retribution.

cont on P8

Mental health in doctors

cont from P7

It is time Mandatory Reporting was aligned nationally with the Western Australian model. If this is to be a role for the COAG Health Council, as has already been suggested by Health Ministers, Brad Hazzard and Jill Hennessy, it should be high on the agenda for their next meeting.

Federal Minister, Greg Hunt, meanwhile has openly committed to the issue of doctors' mental health, although it has been pointed out that his meagre offering of $1M to support this amounts to barely a cupcake per registered practitioner! Sweet? Maybe not!

It is also time that our learned Colleges paid more than lip service to the welfare of their members. ANZCA has had something of a pioneering role here with its longstanding Welfare Special Interest Group, and RANZCOG has more recently initiated in Victoria a number of seminars and workshops led by dynamic psychiatrist Helen Schultz (@drHelenSchultz for the twitterati!).

The RACS' focus on workplace bullying and gender harassment has gone some way to highlighting issues within their ranks. Others, including somewhat surprisingly, RANZCP, have remained silent.

Beyond the Colleges and governments lie opportunities still to be explored. Mentoring, in the sense of an experienced and trusted advisor's input, has been suggested for juniors and seniors alike. This is in contrast to the role of supervisor during periods of training. After all, who is likely to confide in an individual responsible for assuring progress through the ranks? Not having a mentor of choice, but rather by assignation, has been blamed for the failure of some of these programs in the past. I know that having such a mentor has been of benefit to me at different times in my career.

Finally, to the matter of professional care for the carers.

Helen Schultz has reported that this has been a significant focus of workshopped solutions to managing doctors' mental ill health. It is the case that not everyone is suited to treating colleagues. Manipulative, taciturn, poorly compliant… they can be wily critters.

My own lived experience (as a patient!) confirms this. The answer would seem to be the establishment of panels of doctors, notably GPs, in the cities and in the regions who are both willing and trained to take on this role. These are not meant to be mentors or mates, but clinically objective partners in assessment and treatment. And until such panels exist? Everyone of us, without exception, must seek out and retain a GP they have confidence in. It could save your life.

Dr Ian McPhee MBBS FANZCA is APS Clinical Lead, The Tweed Hospital

North Coast kids remain under-immunised

The NSW North Coast continues to lag behind the national rate of early childhood vaccination, with only 90.3 per cent of five-year-olds being fully immunised. This means that 1867 children in this region do not receive the recommended protection against communicable diseases.

The neighbouring Gold Coast fared only one per cent better.

Postcode analysis reveals the local extent of the problem, with Byron Shire's rate of fully immunised five-year-olds, standing at 73.2 per cent, being the lowest rural-regional figure in Australia.

The statistics were delivered in the Australia Institute for Health and Welfare report Healthy Communities: Immunisation rates for children in 2015-16 .

They show that a total of 1867 children between the ages of one and five years living within the boundary of the North Coast Primary Health Network (Tweed Heads to Port Macquarie) remain unimmunised.

According to the report, about 93 per cent of all Australian five-year-olds were fully immunised in 2015-16, up three per cent since 2011-12, but still below the national target of 95%.

"Immunisation is a safe and effective way of reducing the spread of vaccine-preventable diseases in the community and protecting against potentially serious health problems," said AIHW spokesperson Michael Frost.

The report examines immunisation rates across Australia's 31 Primary Health Network (PHN) areas.

"The good news is that for the first time, all 31 of Australia's PHN areas now have immunisation rates for five year olds above 90%," Mr Frost said.

"And the gap we see between the areas with the highest and lowest immunisation rates has started to shrink."

However, the report shows that differences remain across PHN areas.

"When looking at smaller areas, like postcode areas, we see much greater variation in immunisation rates, from a high of almost 100% and a low of 71% for fully immunised 5 year olds," Mr Frost said.

NSW Labor's North Coast watcher Walt Secord claimed the state government could do more to boost vaccination rates, saying, "Mothers in the developing world line-up for hours to protect their children, but we have mothers in Byron and Mullumbimby who put their own children and other children at risk. That is wrong.

"No one has the right to infect their own child or someone else's child. Failing to vaccinate a child is irresponsible.

"Sadly, we are experiencing the re-appearance of diseases which we believed were eradicated. Measles and whooping cough outbreaks have been reported on the north coast."

** Local GP Michael Douglas, who works at the University Centre for Rural Health and Jullums AMS, was asked recently on behalf of the Australian College of Rural and Remote Medicine to join the National immunisation Committee, Australia's peak body on immunisation policy.*

Dr Michael Douglas

Exercise in the fight against cancer

Studies are increasingly showing that appropriate exercise is a valuable aid in helping reduce the risk of acquiring cancer, and improving outcomes during and after treatment, writes Dr Ric Milner. Following diagnosis with metastatic prostate cancer, Dr Milner began "to explore the benefits of exercise and the appropriate application of exercise with cancer".*

Ric Milner's personal story can be read on page 12.

Dr Ric Milner

Although it is relatively early days in assessing the value of exercise as a therapy for cancer and treatment related conditions, there are significant signs that the body can, and generally does, react positively to appropriate physical activity.

Moreover, planned exercise and increased leisure time activity have also been shown to reduce the incidence of cancer.

Among the many benefits identified by researchers are an increased tolerance to chemotherapy and radiotherapy.

From a meta-analysis of new evidence in relation to exercise, diet and cancer (1), 2·5 hrs per week of moderate-to-vigorous activity showed 13% reduction in cancer mortality in the general population 'before diagnosis'. In the same population, 15 metabolic equivalents of task (MET) hrs per week of physical activity showed 27% lower risk of mortality from cancer. (By definition, one MET is the energy required to sit still. Moderate activity is classified three to six METs. Vigorous activity is over six METs).

The same review (1) showed that post-diagnosis physical activity has stronger associations with mortality risk reduction (about 14% greater reduction in risk) than pre-diagnosis activity. In cancer survivors undertaking 15 MET hrs per week after diagnosis, the mortality risk from cancer decreased by 35%.

A systematic review (2) demonstrated that new data supported previous findings. For people who were more physically active, results showed a lower relative risk of cancer recurrence, cancer mortality, and all-cause mortality in breast and colorectal cancer.

Monga et al (8) showed an 8-week cardiovascular exercise program in patients with localized prostate cancer undergoing radiotherapy improved cardiovascular fitness, flexibility, muscle strength, and overall quality of life and prevented fatigue.

In another study, beneficial effects were noted when comparing a higher with a lower intensity exercise program, with significant treatment effects on reducing symptoms only among women in the higher intensity aerobic exercise program, or with the higher intensity program that combined aerobic and resistance exercise.

Exercise and adverse treatment effects

Apart from mortality benefits there are specific benefits from exercise to patients with conditions arising from their treatment. These include:

Bone health

In the systematic review (2), 7 trials were evaluated and showed mixed findings with some showing no benefit from weight training exercise in terms of bone health. One randomised controlled trial (RCT) (8) showed thrice weekly resistance training during 6 months of radiotherapy for spinal metastases showed significantly improved spine bone density compared with passive physical therapy.

Sexual Health

Sexual health outcomes were reviewed (2) in 6 studies: 3 in breast cancer and 3 in prostate cancer. Again, the review showed mixed results.

For breast cancer, one RCT for post treatment breast cancer patients showed improved scores for sexual activity and sexual pleasure with combined cognitive behavioural therapy and a 12-week home-based exercise program. In another study, no significant difference was seen by an intervention either during or after radiotherapy.

For patients with prostate cancer receiving androgen deprivation therapy, a 3-month program including aerobic and resistance exercise improved sexual function scores. However, another study with supervised walking sessions per week had no effect on sexual health among patients with prostate cancer post-surgery.

Fatigue and Muscle weakness

For symptoms associated with cancer and its treatment, fatigue has the best evidence of a significant beneficial effect from exercise. All three major studies of patients fatigued by chemotherapy showed a significant benefit from exercise.

Patients with cachexia have great trouble maintaining muscle mass as well as fat deposits. Exercise is the only strategy that has been shown to have any effect on reducing muscle mass decline with cachexia.

A study of biomechanical function of men (3) with prostate cancer who are treated with androgen depletion therapies (ADT) showed muscle loss patterns that are not consistent across all muscle groups. The study demonstrated a reduction in peak torque of hip flexors (14%) and knee extensors (16%). Specifically, iliopsoas, quadriceps and soleus function were affected. Over time this results in a wider based gait and increase rates of falling.

Exercise programs probably need to target these muscles specifically although there are no studies yet to show this strategy works.

Cognitive health

Two of 5 studies reviewed (2) showed significant improvements in cognitive function, including an 8-week aquatic exercise program conducted post treatment for breast cancer, and a 4-week once weekly cycle "ergo" program for patients with breast or prostate cancer.

cont on P10

Exercise and cancer

cont from p9

Psychological distress

Ten meta-analyses (2) showed significant improvements in one or more of psychosocial outcomes among cancer survivors randomized to exercise compared with those randomized to a comparison group. Two studies did not show benefit.

Bowel and bladder function

Exercise resulted in significant improvements in bowel and bladder outcomes in 2 of 5 trials. One was a 6-week yoga intervention that improved constipation in breast cancer survivors post treatment. The other was a twice weekly resistance, flexibility, and kegel exercise intervention in elderly patients after radical prostatectomy for prostate cancer.

Body image/sleep etc

Cormie et al (2) reported on their meta-analysis findings regarding body image, sleep, physical function, physical health, and shoulder dysfunction. They concluded "With few exceptions, the conclusions of several meta-analyses are that exercise does have a significant positive effect on these outcomes".

Quality of life

3 of the 4 meta-analyses findings (2) in breast cancer, and 2 which focused on haematological malignancies, reported significant improvements in quality of life for cancer survivors who exercised compared with those randomized to a comparison group. Evidence did not support a positive effect of exercise on quality of life in prostate, lung, colorectal, or gynaecological cancer survivor.

Immune Therapy and Exercise

Interestingly in the era of immune therapies it seems that the benefit of exercise is probably via immune changes. Using mouse models, Idorn et al (4) demonstrated that "voluntary exercise leads to an influx of immune cells in tumours, and a more than 60% reduction in tumour incidence and growth".

It appears there is evidence that data is accumulating (4) "to suggest that patients whose tumors are characterized by a brisk infiltration of immune cells are more likely to respond to treatment". As a result of this information, there is interest in "methods by which tumours with limited or absent immune cell infiltrates, i.e., "cold tumors" can be turned into "hot" tumors with an infiltration of anti-tumor immune cells, T cells, NK cells, dendritic cells, etc".

In addition, "exercise prior to PD-1 therapy could represent a tool that condition patients to immunotherapy by increasing the immune infiltrate in the tumor, and in turn increase the chance for clinical response".

Evidence (4) points at the immune system as being crucial also for the efficacy of chemotherapy. If substantiated by human studies, exercise could play a role by improving the immune response to conventional chemotherapy treatments.

Safety first

Many of the recommended exercise programs involve weight training as well as aerobic processes. The problem of weight training in a patient with metastatic disease in bones, is the risk of fracture. There have been several tools developed to try to assess this risk but they have been shown to be inaccurate.

Patients therefore need to start their weight training with low weights and gradually increase the load to gain the benefits. If a patient develops pain whilst doing the loaded exercise, he or she should reduce the load and seek advice from their medical team.

This is particularly important if a previously pain-free exercise becomes painful. The site of the pain then needs investigation.

There is also the risk that patients may feel that they have failed when the disease progresses despite their best efforts at exercise. The aim of treatment needs to be clear before embarking on an exercise program. The patients need to understand that exercise is not a cure, but an important adjunct to improving their chances of survival, and more importantly improving their quality of life.

When a patient's cancer progresses despite surgery, chemotherapy, radiotherapy, immunotherapy or exercise, the therapy failed the patient, not the other way around.

Dr Ric Milner is a Victorian GP of the Year, and has worked in a wide range of clinical roles. He is based at the You Yangs Medical Clinic, Lara, Victoria.

References ***can be viewed on the website***

Dr Ric Milner graduated from Monash University Medical School in 1977. His internship and following residency was at Geelong Hospital, southwest of Melbourne. The establishment of the Family Medicine Program by the RACGP occurred in 1973 and he undertook his medical training in General Practice under its auspices.

Dr Milner has been a supervisor for general practice registrars for more than 20 years, and he lectures in sexual health at Deakin University in Geelong.

Dr Milner chose a career in general practice, working at both Corio and Lara Community Health Centres, and later became a founding general practitioner at You Yangs Medical Centre in Lara, a suburb of the City of Greater Geelong.

He was involved in a collaborative project in the Geelong region to develop a process for initiating and completing advanced care directives from general practice. This has been the most successful advanced care plan process in Australia.

In his professional life he has been dedicated to the complex job of general practice as well as the areas of HIV medicine, venereology, ad drug and alcohol medicine. He has also been a doctor in the Victorian Prison system.

He is a board member of the Western Victoria PHN.

Dr Milner is a cycling enthusiast and rides at least 200 km per week. He follows a highly controlled medium load gym workout twice per week and averages one swim per week of around 1 km. He has been researching the benefits of exercise as an independent factor in the management of patients with cancer.

His award of Victorian GP of the Year for 2017 is a well-deserved honour.

A grand run on the Great Wall

by Dr Kim Kerr

Fourteen members of the Lismore Runners group flew to China recently to participate in one orother of a series of the Great Wall runs, a marathon, half-marathon, 10 km or 5 km. We ranged in age between 55 and 70 years.

The first wall was obtaining visas – two of us had our applications rejected and needed to fly to Sydney for new passports, receiving the visas with only two days spare.

When we flew into Beijing we had a few days to sightsee before the actual run. Of course Tienanmen Square was one of the first places we visited. Our guide warned us not to mention the words Taiwan, Tibet, or tanks/riots while in the square, as there were lots of people listening and she could get into trouble.

In fact, each light post had about six CCTV cameras watching us, and apparently there were lots of plain clothes police officers around.

The weather was lovely – clear blue sky, the flowers out and no smog, which was what I had been hoping for.

The day of the run was clear as well, and we were all up at 4.00 am for the start – 90 minutes there by bus. The scenery on the wall was spectacular – rolling green mountains for miles around, with the wall snaking over the tops of all the ridges. Even better, hardly any other tourists.

The run itself was extremely difficult – so steep up and down – most of the way it was old stone steps, some short, others high. Sometimes there were no steps, but it was still incredibly steep, and going downhill on these parts was like walking down a roof.

Three of us did the marathon of 42 km; five (including me) the half marathon of 21 km, three the 10k, and three the 5k.

Needless to say our times were nowhere near what they normally are for these runs. I think you could say that on average we took two and a half times our usual.

However it was a great experience; the scenery was wonderful, and the camaraderie as usual was special, but we were all pleased to get back to our hotel that evening, clutching our very large and pretty medals, and harbouring feelings of accomplishment.

Members of the Lismore Runners Group in China

The oldest in our group was 70 – he did the marathon more easily and quickly than anyone – and I think could walk better than anyone the next day.

After this we still had a week left in China. We caught the high-speed train to Hangzhou where we visited the beautiful Westlake, and a tea plantation, then Shanghai.

The Bund in Shanghai is the colonial part, on the river, and on the other bank is the modern very high-rise sector. It's a gorgeous view looking across at all the architecturally designed high-rises. And of course seeing it all by night is beautiful too.

China is meant to be an undeveloped nation; but it seemed so much more developed than Australia in terms of road systems and other engineering feats.

In Shanghai there were times when you could look down and see five more layers of roads underneath, all spaghettiing around to reach different destinations.

Some of us took the subway into the centre - extremely organised and enjoyable journey, easy for us to navigate even though we had no Chinese language.

The final three days of the trip were spent on a cruise of the three gorges part of the Yangtze river, starting at the famous dam and finishing at Chongching.

Before the three gorges dam was built, thousands of people would die each time the river flooded. The dam caused the water level upstream to rise 100 metres. More than a million people were relocated to high-rise villages, which were purpose-built before the dam was completed in 2012. The function of the dam is threefold – protection against floods, hydroelectricity, and the navigation of ships on the now wide and deep river. As well as locks for the ships there is a concrete boat lift.

The scenery in the three gorges was beautiful – really high cliffs, which must have been even more majestic before the dam caused the river level to rise 100 metres.

Running is a great excuse to travel, and a great way to get different perspectives on other countries.

Dr Kim Kerr is a Northern Rivers GP and, like her husband Dr Charlie Hew, a running enthusiast.

Prostate Cancer - a personal account

by Dr Ric Milner

In October last year I had a conversation with a friend of mine who lives in Ballina. He had recently been found to have a positive lymph node in the retroperitoneal space from his long-standing prostate cancer. He, like me, is a keen cyclist and I convinced him that as his disease was not curable that it was about time that he went riding with me in Italy. I had been bike riding at "Bike hotels" in Italy several times before, and had been trying to convince him that he should come to Italy with me for several years.

He has had prostate cancer for more than 10 years but the finding of a positive node after radiotherapy convinced him that life is short and he should enjoy it so he agreed to ride with me in Italy. During this time several of my other bike riding friends became enthused and there are now 12 of us going at the end of August.

In February this year I developed chest pain and reluctantly attended accident and emergency for assessment. During the work up I was pleased to find that I did not have any evidence of cardiac disease but unfortunately there were sclerotic and lytic lesions seen in my thoracic spine on CT scanning.

Bone scanning revealed multiple lesions throughout my skeleton including my skull, maxilla and extensive disease in the pelvis and spine. There are also lesions in the long bones of both upper and lower limbs. I am pain free apart from the long-standing mechanical back pain that I have had since I was 17.

I had a PSA of 512 and have since had chemotherapy and androgen depletion therapy.

I gained weight and developed considerable oedema with chemotherapy and dexamethasone.

The dexamethasone was required to decrease the oedema associated with taxane chemotherapy but made me very hungry and grumpy and affected my sleep.

During the chemotherapy I maintained as much exercise as I could and I found that I had less symptoms of fatigue and slept better when I forced myself to get off the couch and do something. This was not an easy thing to do because the chemotherapy made me feel pretty terrible but my symptoms, even during the worst five days after each dose were diminished if I went for a short walk.

As the worst part of the chemotherapy wore off, I was able to continue riding and swimming, certainly not at the same level as before, but I felt both physically and psychologically considerably better.

Importantly I felt I had some control of this process that had been thrust upon me.

I began to explore the benefits of exercise and the appropriate application of exercise with cancer.

I have read extensively and discussed concepts with an orthopaedic surgeon friend who has a special interest in cancer orthopaedics.

An oncologist friend of mine has helped me find appropriate literature and this has been a fascinating and useful process for me.

Last week I rode 328 km mainly on a road bike, but some on a mountain bike.

I swam 1 km twice and went to the gym for two sessions. The research and reading that I have done has helped me tailor my exercise regimen to be as safe and as effective as possible.

I feel much better without the chemotherapy and I am beginning to get a positive training effect from the exercise. During the chemotherapy my exercise ability gradually declined but I was still able to ride 70 km at a time but not at a fast pace.

The kindness shown to me by my bike riding friends deserves special mention. They waited for me and helped me by protecting me from the wind and tolerated my inability with "boy style" humour and good grace and love.

" You're riddled with cancer and as fat as a pig and your testicles are as big as peas but you still beat me up that hill you prick"

I really miss having testosterone for multiple reasons, not just the insult to my concept of myself as a sexual person, and my "manliness" and considered going back onto testosterone prior to my trip to Italy.

Training didn't seem to be working much but I ceased chemotherapy about six weeks ago and I am at last gaining fitness again, albeit more slowly than when I did have normal levels of testosterone.

Having almost zero testosterone also results in moderate anaemia but this may take several more months before it becomes significant.

If I had not exercised throughout this process, I am certain that my quality of life would be hugely impacted by the treatment that I have a experienced.

I know that there is the potential to extend my life a bit with exercise but my main motivation is not the extension of my time on the planet but the maximising of my enjoyment of that time.

Sorry, the doctor might not be coming

by Dr Andrew Binns

I arrived in this region nearly four decades ago, setting up my own solo practice in April 1979 and some years later gained an associate to share the workload. A major factor in encouraging more cooperation with colleagues was the need to provide after-hours care for our patients.

The challenge was to balance this commitment with family life, including factoring in holidays, plus the demands and expenses that come with running a practice to the level expected by patients and the various regulatory bodies.

As the years passed it became harder and we established a roster for sharing after-hours calls. This included obstetrics cover for some relevantly trained practitioners, including myself. However, even a three-practice amalgamation did not solve the burden of after-hours care provision, so we began to cooperate with other neighbouring practices to further share and manage the workload.

There were numerous supporting schemes through the evolving NRDGP, NRGPN and later the NCML. These worked to help us balance the competing demands of family life and work. But after a political change in Canberra and the establishment of Primary Health Networks the incentive funding to provide an after-hours service radically changed.

This signaled the advent of after-hours deputizing, bulk billing home visit services run by corporate entities. Some non-GP doctors were also employed in these services.

Not surprisingly, this has proven to be somewhat of a winner for patients who only have to ring to get home-service medical care that is bulk billed. By eliminating a gap fee for those who cannot afford one, this scheme provides no-cost access to after-hours medical care that was previously not available without attending an emergency department.

Those GPs who were previously providing after-hours service could pull back a bit and do less after hours consulting, while still providing a phone service, as well as practice visits, nursing home or home visits if necessary for genuine emergencies.

The latest arrangements have begun to alarm the Federal Government, which is now concerned at the huge cost blow-out for providing an additional service underwritten by Medicare. There is also concern that not all after hours visits are for true emergencies but rather for convenience in dealing with routine health matters.

A much-vaunted justification for this financial commitment was that it would reduce the escalating number of Accident and Emergency presentations, which are even more expensive than primary level care.

However there appears not to have been a reduction in hospital presentations. This apparent failure of the home-visits scheme is of mounting concern to Federal and State health funders, who are responsible for the clinical staffing of public hospitals where after-hours demands are continuing to rise, especially with the regular spike in winter.

So where are we now with this ongoing and complex matter?

As reported in GPSpeak, the MBS Review Taskforce has proposed that GPs who normally work in-hours but are providing urgent after-hours services will still be able to claim the larger Medicare item fees for after-hours attendances. Under such a change, doctors working for corporate deputising services will be limited to billing Medicare for non urgent consults, which is a much lesser fee. This draft report has gained the support of the AMA and RACGP.

However there are many headwinds for the Government in putting these measures into place.

The National Association of Medical Deputising Services will fight to save the business model that underpins them, with some questioning of the research that has led to the conclusion about the number of A&E visits not diminishing.

The current arrangement may have some personal advantages for GPs who provide comprehensive in and out-of-hours services. On a recent weekend when on after-hours duty, I received only a single emergency call. Last winter, under previous arrangements, I would have seen about 20 patients at my surgery, with receptionist support.

But the government, i.e. the Australian taxpayer, is footing a hefty bill to achieve a result that is not the main reason for the scheme, and cost is only one of the challenges. The stakes are high and many competing interests are at play, with politics and health economics being key factors in the mix.

When decisions are finally made, it will be fascinating to see the responses from the deputising services lobby, the medical bodies and of course the general community whose interest in the topic is yet to be fully aroused.

University Centre for Rural Health North Coast welcomes UOW students

advertorial

In July this year, 21 University of Wollongong (UOW) third year students began their longitudinal 12 month placement in our region. They will be living, studying and learning across the North Coast University Centre for Rural Health (UCRH) footprint of Murwillumbah, Lismore and Grafton.

Third year group of UOW students

These students are placed in hospitals across our Local Health District and in General Practices, where they will have access to patients from the local hospitals and community health settings. The GP placement will allow students to experience continuity of care for their patients and provide a range of opportunities in acute medicine, chronic care, interdisciplinary learning and population health.

Students at NAIDOC celebrations

Orientation week enabled the students to participate in NAIDOC celebrations and spend time with the UCRH Aboriginal Education Team, Emma Walke and Darlene Rotumah. Students were also able to participate in a number of activities at the Southern Cross University NAIDOC celebrations.

Students at NAIDOC celebrations

During the next 12 months these students will develop their clinical competence and come to better understand what it means to practice medicine in our community.

❖ ❖ ❖ ❖ ❖ ❖ ❖

UOW 1st year students visit the region

The UOW rural taster provides a scholarship based opportunity for first year UOW medical students to experience the challenges and diversity of healthcare systems in rural communities. These six students have been living and learning in our region recently.

Students, Nicholas and Megan at Ballina ED

UNIVERSITY OF WOLLONGONG AUSTRALIA

They have been to Ballina Hospital, Kyogle / Ballina / Casino /Lismore community health centres and Bullinah AMS. During these placements students perform basic patient care activities such as recording and monitoring vital signs, assist with assessments such as safety in the home.

Georgia home visiting a local identity.

Comments from the students:

Thanks for having us up at Ballina / Lismore and surrounds! I really enjoyed the stay! Ballina ED was most definitely my favourite of all.

Thank you so much we have all had an amazing time! Thanks for facilitating such a great placement for us. You can bet we will be applying to come back for our 12 month clinical placement in Phase 3!

Supporting GPs in addressing chronic disease care

by Dr Jane Barker

By definition chronic diseases are diseases we cannot cure and at best can attempt to control symptoms and delay complications and progress. The care of patients with chronic diseases is consuming increasing general practice hours. They contribute to 60% of deaths globally and this figure is increasing on an international scale. It has been estimated that if the current trend persists, diabetes alone could consume the entire health care budget of western nations.

While much of our population lives longer they do not necessarily live with optimal health, being limited by their physicality, their pain, the psychological reaction to their problems and by current management itself.

Finding ways to effectively and efficiently prevent, manage and potentially cure these diseases is the challenge for the new generation of clinicians.

Multiple-morbidity

Not only do a majority of patients over 65 have at least one chronic disease diagnosis but many have two or more. In General Practice approximately 34% of patients seen have 3+ chronic disease diagnoses. Multiple morbidity significantly increases the complexity of patient care making it more challenging - although perhaps more professionally rewarding for us as GPs.

For the doctor the challenges are in the multisystem disease requiring multiple medications and management approaches when there are inevitably drug side effects, interactions between drugs and systemic disease which may affect drug efficacy and safety.

Management guidelines, evidence based and useful as they may be, most often address one specific diagnosis, so how does that apply when the patient has four or five? Coordination of management and ensuring continuity of care are vital in successful treatment.

And then there is the "care" word, so well used by Peabody in 1925 and still holding true today - "The secret of the care of the patient is caring for the patient".

These are the patients that a GP gets to know well, thus deepening that special bond that is the doctor/patient relationship, deepening that connection which allows a very comprehensive understanding of the patient's unique resources and needs, and requires that higher level of communication.

Patient issues

For the patient too there is a complexity - multiple referrals that consume time and money, multiple medications, multiple recommendations for lifestyle changes often conflicting and confusing.

This brings in the innovative concept of the patient centred medical home - a model local GP Tony Lembke promotes and champions – that attempts to optimise and rationalise management and most importantly, if there is to be success at all, to engage and empower the patient to take a central role in their own health care.

Wanted: orchestra conductor

Ever exponentially increasing, the level of medical knowledge has of necessity, caused a fragmentation in specialisation. Increasingly we are seeing the emergence of sub-specialties, and sub-specialties beyond them. There are cardiologists with amazing expertise and technical skills in the management of atrial fibrillation but who do not manage ischaemic vascular disease; orthopaedic surgeons who only perform knee replacements. Therein lies a problem. The human body is in itself not fragmented... mind, body and soul are one.

We have a conundrum. How does our patient with multisystem disease get the best care without this sense of each body system being managed by a different health care provider, and the risk that these are not communicating effectively with one another?

We need a conductor for this orchestra, a conductor. Traditionally this has been the role of the GP but with the increasing complexity of care GPs need to be properly funded and fully supported to coordinate a complicated care equation that is far beyond a 15-minute GP appointment. Without coordination, as in the tale of Humpty Dumpty...

"All the kings horses and all the kings men

Couldn't put Humpty together again"

Valuing physician generalists

In our area we are blessed by having several highly competent physician generalists, but they are an aging, if not yet, a retiring breed. Few physician trainees are taking on this role, yet these clinicians are gold for GPs when it comes to problems in the complex management of patients with complicated, multiple morbidities.

Of necessity GPs have to take a holistic approach to patient care, but there are times when the wisdom and expertise of a generalist physician, bringing fresh eyes to our patients' problems, are invaluable. I have always considered these clinicians to be the true masters and teachers of medical care. In fact, recently I watched in awe as such a physician taught a bunch of my students the nuances of neurological examination in differentiating the site of a CVA. He displayed true artistry.

cont on P 16

Bundjalung art coming to new Lismore Regional Gallery

by Dr Andrew Binns

In 2004 and 2009 a large exhibition of the work of Aboriginal artists was held at Lismore City Hall. Inspired by local doctors working in Aboriginal Medical Services, the initiative was highly successful on many fronts. There were sales of more than $50,000 for each of these exhibitions, which provided income for the participating artists as well as some profit that could be directed to further develop the local Aboriginal art industry and acquire some for equipment for the Casino AMS.

The years have passed, and the need to do more in the field of Indigenous art in this area remains pressing. In response a number of partners have come together to support an Art on Bundjalung Country event, including the NC Primary Health Network, Arts Northern Rivers, Lismore Regional Art Gallery, Bulgarr Ngaru and the University Centre for Rural Health North Coast.

The idea is for established Aboriginal artists to conduct a number of workshops for emerging artists living on Bundjalung Country from which work will be selected for an exhibition at the new Lismore Regional Gallery in December. The work will be for sale. Workshops will be held in Lismore, Brunswick Heads, Maclean, Casino, Nimbin and Tweed Heads. The art forms will include painting, basket weaving, installations, and ceramics.

It is envisaged that this will further stimulate the art industry to meet the growing market for Aboriginal work. It is hoped such work will be seen in health facilities, foyers, waiting rooms, shops and homes in the region and beyond. Marketing and promotion will be part of the project.

The benefits go well beyond the business case. Inter-generational trauma is a problem for many Aboriginal families and this can stem from past dispossession from land, language, culture and identity, along with racism and discrimination.

For healing to take place there needs to be a much better understanding of our nation's 60,000 year history and the truth told around the overall negative impact of colonial settlement for Aboriginal people. The arts in its many forms play an important role here.

Aboriginal art is a powerful way of discovering, understanding and building respect for Goori culture. Art in all forms plays a key part in this through both visual and performing art, which includes paintings, sculpture, dance, music, story writing, theatre, film, rapping, crafts and more.

Art is one of the best therapies for healing. For many people (Aboriginal and other) suffering from major trauma leading to mental health problems art is a safe and effective way of expressing anguish and emotion using non-verbal communication. We can see many examples of this as a healing process in our community.

NCPHN's senior project officer for this project is Bundjalung artist Sarah Bolt. She has demonstrated extraordinary leadership skills by encouraging established Bundjalung artists to become workshop facilitators. She is now encouraging emerging Aboriginal artists to attend workshops that could give them a unique opportunity to exhibit at the new Lismore Regional Gallery later this year.

Enquiries about this project can be directed to Sarah Bolt on 02 6615 8440 or 0409 322 733.

Donations to expand the scope of this project can be sent to:

Arts Northern Rivers Gift Fund

BSB: 032 573 Acc: 263 269

All donations to this account over $2 are tax deductible - a receipt will be issued after deposits are received.

Supporting GPs

continued from P15

It would be wonderful if in our work with medical students we could encourage those drawn to physician training to consider taking a generalist's role. It is a difficult role requiring as it does multidisciplinary expertise, but the burgeoning numbers of patients with chronic and complex disease make it a vital role in today's health care.

❖ ❖ ❖ ❖ ❖ ❖ ❖

One such local physician is Frank Wagner who has recently received a reward for long service to this rural region. "Everybody loves Frank" was the comment I heard more than once. As a GP I have always felt respected and valued by him, no problem I shared too small for him to assist with, never made to feel lesser than. Frank had already been working in Lismore for 8 years before I arrived in the area over 30 years ago. I had an immediate connection with him because we had both worked in New Guinea. Frank is so much more than a most knowledgeable physician generalist.

Dr Frank Wagner

He has been a wonderful role model to several generations of doctors. He treats everyone from junior doctors to trainee nurses and all of his patients with utmost dignity and care, treating all as equals. He has shown us all what love looks like in medical care and set a standard which I believe has influenced the care at Lismore Base Hospital for many years.

** Local physician, Dr Frank Wagner , was recently honoured by the Northern NSW Local Health District in recognition of his award from the Royal College of Physicians.*

Aboriginal health merger a case of 'doing the right thing'

In a major boost for Aboriginal health and wellbeing in the Lismore area, a partnership has been formed between Rekindling the Spirit, which provides counselling and other support services, and Jullums Aboriginal Medical Service (AMS).

Jullums, previously managed by the federally-funded North Coast Primary Health Network, will become part of a broader, community-controlled health service. Both bodies will retain their current names and staff.

In one of the moving speeches that marked the celebratory event today (5 June 2017), Rekindling's CEO Greg Telford said that life experiences and speaking with the Elders every day in his prayers had convinced him that if you "do the right thing, the right things happen."

All present clearly agreed that this merger of the two well-regarded organisations was a good example of the 'right thing'.

The event was held at Jullums in Uralba Street, near Lismore Base Hospital, and included traditional dances from former mates at Goonellabah Public School, a Welcome to Country by Uncle Mick Roberts, a familiar figure who sits on the new organisation's committee, and a range of speakers.

NCPHN Chief Executive Dr Vahid Saberi said, "We were pleased to be assured that Rekindling the Spirit had all the required capabilities for the ongoing delivery of quality and safe health care to the Aboriginal community of Lismore."

Greg Telford and Services Manager Jeff Richardson thanked the many past staff of Jullums and its present team who had done such a great job in taking the AMS this far:

"In particular, thanks go to Dr Andrew Binns who has worked at and been a great supporter of Jullums AMS for many years. And we really want to thank North Coast Primary Health Network for managing Jullums, supporting it and handing it over to us on a sound financial basis. We look forward to expanding and growing the health service."

Mr Telford spoke warmly about the work done by Jullums (formerly Gurgun Bulahnggelah) over the years, saying he was honoured that the community had faith in his organisation to move forward and expand into a fully-fledged AMS.

"We are all about the community having a say in their health care and look forward to being able to provide real job opportunities for Aboriginal people so that they can become qualified and gain work anywhere," he said.

Federal MP for Page Kevin Hogan, North Coast Primary Health Network CEO Dr Vahid Saberi, Dr Andrew Binns and Rekindling the Spirit CEO Greg Telford.

Rekindling is taking ownership with the support of Aspen Medical, a global health care provider and philanthropic organisation, which, in accordance with the arrangement, will be available to support the AMS with clinical governance advice, funding in its early stages if necessary, and will provide health care staff to fill gaps if needed.

$100,000 drug & alcohol - mental health funding

The event was combined with an announcement by the Federal MP for Page Kevin Hogan that funding of almost $100,000 is being allocated to a pilot program tackling drug and alcohol use and mental health issues within the local Indigenous community.

The funds are from the Indigenous Team are allocation that supports the coordination of care and other services for AMS clients. Its goals include improving access to D&A treatment services, better integration of mental and health and D&A services, and early intervention services for young Aboriginal people.

"It is important that we address drug use and mental health issues in all our communities," Mr Hogan said.

The program is designed to be culturally appropriate for the local indigenous community and tailored to meet the needs of each individual.

"I would also like to congratulate Rekindling the Spirit which will run this program and is also taking over the management of Lismore's Aboriginal Medical Service, Jullums."

Tax Time : Be prepared

If you're coming in soon to discuss your tax return or your business's tax return, try not to turn up empty handed.

Being prepared is a wise approach for everyone, especially at Tax Time. It will also save a lot of time and effort for you and for us.

If you are a new client, always arm yourself with last year's tax return. This should have your personal details, tax file number, income streams, tax offsets, deductions, and other relevant information. Also have your bank account details in the event that you're entitled to a refund.

What to bring?

Here is a general checklist of things to prepare for your tax return appointment. Not all of the following will be relevant for everyone, but will depend upon your own circumstances.

Income

- PAYG summaries from employers
- Bank statements for any interest received during the financial year
- Distributions from trusts, partnerships, managed super funds
- Allowances (car, travel, entertainment, meals etc)
- Government pensions and allowances
- Foreign income
- Capital gains – for example, sale of shares or property
- Dividends
- Personal services income
- Net income/loss from business
- Rental income – for example, from an investment property
- Lump sum termination payments
- Superannuation lump sum payments

Expenses for tax deductions

- Motor vehicle expenses based on business use percentage and kilometres travelled (include your log book if applicable)
- Travel and accommodation information – domestic and overseas
- Work uniforms and other clothing expenses
- Courses, education and seminars
- Home office expenses
- Computer, software and repairs
- Tools and equipment
- Employee costs
- Superannuation contributions
- Rent/lease payments
- Interest paid – for example,say on an investment property loan
- Dividend deductions
- Bank fees
- Telephone and internet costs
- Utilities – electricity, gas, water
- Legal and accounting fees
- Donations
- Income protection insurance
- Details of any asset purchases

We recommend that you keep receipts for all expenses and possible tax deductions you are considering claiming for you or your business.

If you're in business

Further to the above information, we may also require the following information:

- Online access to or back up of business accounting software
- Bank, loan and credit card statements
- Lease, hire purchase, chattel mortgage or other loan agreements to your business
- Business Activity Statements, Instalment Activity Statements and working papers

Contact us and we will help guide you through the process

TNR Thomas Noble & Russel
Accountants | Auditors | Business Advisers

TNR WEALTH MANAGEMENT

Should you have questions regarding accounting or tax advice, wealth management/creation, superannuation, insurance, retirement or other financial planning need, please call us on 02 6621 8544 or visit tnr.com.au or tnrwealth.com.au

"My leg's still crook, Doc"

- A Modern Approach to Musculoskeletal Pain Management

by Dr David Guest

"It's all in your head", noted rogue London neurosurgeon, Henry Marsh, on a recent visit to Australia.

As someone whose tamperings have altered more people's memories and capabilities than nearly any other, he speaks with some authority. Marsh asserts that the brain is the ultimate integrator of the psyche and the soma, and that its role in formulating our perceptions is paramount.

Nevertheless, convincing patients that the brain is where they feel their calf pain is a common and often difficult task for GPs.

"The problem's in your back where your sciatic nerve is getting squished. However, you feel the pain is coming from where the nerve goes, and that's down your leg. You're actually aware of the pain because of the nerves going the other way, up to your brain."

"That's not much comfort, doc. How about some pills to get rid of the pain?"

This seems like progress. At least we both agree that the final common pathway for pain perception is the brain. However, our therapeutic armamentarium has been sorely depleted in recent years. Paracetamol, non-steroidals and pregabalin have all had their day in the sun, only to be deemed ineffective by night fall.

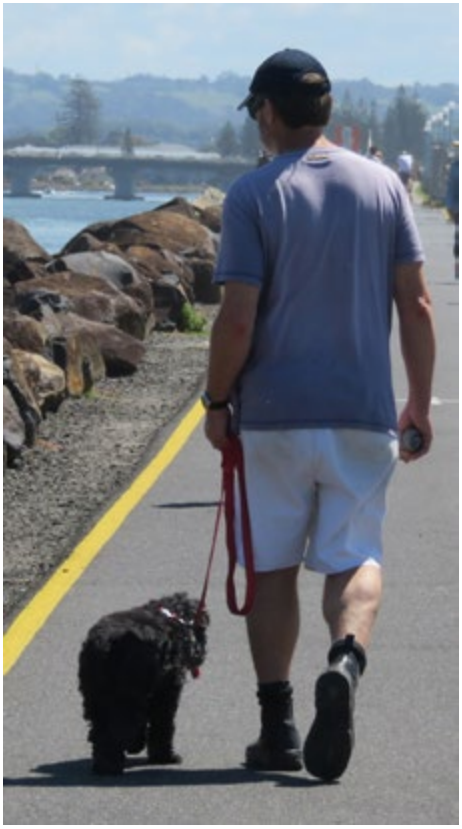
Narcotics are not much better (and may be worse) and Australia is on the same path to a prescription opioid epidemic as is currently being experienced in the USA. On recent figures three million Australians, received 15 million prescriptions in 2014 and 600 people died.

"You're not much of a quack are you, doc? The chiro reckons he'll get me sorted if I sign up for his two year maintenance plan."

"What about one of them MRIs? My neighbour's got some bulging discs and he's a lot better after some spinal injections."

Unfortunately the correlation between symptoms and MRI changes is poor. Degenerative or narrowed discs occur in more than 60% of cervical spine MRIs in asymptomatic subjects aged more than forty.

Even if something shows up, in the absence of focal neurological symptoms, it is unlikely that injections will provide more than mild short term relief. The results for spinal fusion are not much better.



In recent years it has been appreciated that patients' resilience plays a major role in chronic pain. Anxiety, depression, stress and a tendency to catastrophise issues contributes greatly to a patient's perception of pain. Similarly, as has been previously discussed in GPSpeak, low job satisfaction and adverse early childhood experiences are also associated with a more severe experience of pain.

As a result, a more comprehensive approach to pain management using a biopsychosocial approach has been the focus in recent times.

The Local Health District's Pain Management Services have been a great resource for North Coast GPs and their patients, but demand far outstrips their capacity. Thankfully, chronic disease management plans allow patients to link up with exercise physiologists and other health professionals to manage their pain.

"So what are we going to do now, doc?".

"Well you've had the pain for more than three months so this is not going to go away in a hurry and there's no magic bullet. We don't want to waste your money and we don't want to make you worse. Some people see physios or chiropractors or masseurs. Some people like acupuncture but the things that work best are the ones where you move.

"Losing weight helps and eating sensibly is the best way to achieve it, but we probably should have started with that 10 ten years ago. Nevertheless if we can get your weight down 5 kg, we should see a 30% improvement in your knee pain and function.

"You need an exercise program. People often do yoga, tai chi or pilates. The cartilage in your knees and back has some restorative capacity and the best way to stimulate that is with light impact exercise.

"How about buying a dog, and walking it at 6 am every morning?."

To know more about the science behind this approach, Dr David Hunter, Professor of Medicine at Sydney University, has summarised our current understanding of the optimal management of musculoskeletal pain and also explained it in conversation with Dr Norman Swan

COASTAL VASCULAR GROUP

Coastal Vascular Group is proud to be a sponsor of GPSpeak, supporting GPs in Northern NSW. As one of the largest regional vascular practices in Australia, we are committed to providing a comprehensive world class service to the people of the Northern Rivers and surrounds. Our main office location is at St Vincent's Hospital, Lismore and we provide an outreach service at numerous locations. Our practice specialises in the latest minimally invasive treatments for arterial and venous disorders.

Dr Dominic Simring

BA BSc(Med) MBBS (Hons) FRACS (Vasc) Vascular and Endovascular Surgeon
Senior Lecturer, School of Medicine, UWS Supervisor of Surgical Training, Lismore Base Hospital Member, NSW Regional Board in General Surgery

Dr Anthony Leslie

BSc(Med) MBBS FRACS (Vasc)
Vascular and Endovascular Surgeon
Senior Lecturer, Department of Anatomy, University of New England Rural Clinical School
Vice-Chair Anatomy Sub-Committee, Royal Australasian College of Surgeons

Special Interests : Carotid stenosis - Thoracic and abdominal aortic aneurysms - Peripheral vascular disease - Leg ulcers - Diabetic foot disease - Dialysis access (fistula) construction and maintenance - Varicose veins including minimally invasive radiofrequency venous ablation and sclerotherapy

CONSULTING LOCATIONS:

Lismore – Level 2 Suite 4, St Vincent's Specialist Medical Centre, 20 Dalley Street
Ballina – John Flynn Specialist Suites, 79 Tamar Street
Casino – North Coast Radiology, 133-145 Centre Street
Grafton – Specialist Suites, 146 Fitzroy Street
Glen Innes – East Avenue Medical Centre, 39 East Avenue
Armidale – 3/121-123 Allingham Street
Tugun – Suite 2B, John Flynn Medical Centre, 42 Inland Drive

Contact details: - **Ph:** (02) 6621 9105, (02) 6621 6758 **Fax:** (02) 6621 8896
WEB: - www.coastalvascular.com.au
EMAIL: - info@coastalvascular.com.au

FRACS Fellow of the Royal Australasian College of Surgeons

‘Miracle machines’ help stroke patients’ recovery

by Robin Osborne

Stroke survivor Murray Shergold, a chipper 70-year-old from Woodburn, was told by specialists in Brisbane that he should not expect to ever walk again after suffering a stroke.

Stroke survivor Murray Shergold receiving muscle stimulation from the RT300 Functional Electrical Stimulation Ergometer at NeuroMoves in Southern Cross University’s Health Clinic. Pictured l-r - Exercise Physiologists Kate Schaefer and Sam Mitchell, Graham Batten from Newcastle Permanent Charitable Foundation, and Southern Cross University’s Vice-President Global, Chris Patton.

Now, just months later and after weekly sessions on the RT300 Functional Electrical Stimulation Ergometer in the NeuroMoves gym at Southern Cross University Health Clinic, Murray is beginning to walk without a stick.

To say he’s pleased is putting it mildly, and the same goes for his wife Jean, who runs a local nursing service as well as an orchid business.

“I’ve got energy and I’m continuing to get better,” Murray said at the official opening of the facility that has been operating since last March.

“The difference has been incredible,” Jean Shergold told GP*Speak*. “We thought he’d be wheelchair-bound for the rest of his life, but the progress has been absolutely amazing.”

Supported by the excellent clinical staff at

John Gwynne from Coraki exercising on new equipment at NeuroMoves, with (l-r) Therapy Assistant Jarrad Speers, SCU Health Clinic Manager Marlene Assim, EP Kate Schaefer, Spinal Cord Injuries Australia CEO Peter Perry, Newcastle Permanent Charitable Foundation’s Graham Batten, and EP Sam Mitchell.

NeuroMoves, Murray’s progress is largely attributable to the RT300, valued at more than $50,000, and the only machine of its kind in the Northern Rivers, with no other between Sydney and Brisbane.

As exercise physiologist Sam Mitchell explained while hooking Murray up to a complex set of electrodes, the device provides direct electrical stimulus to a patient’s muscles, bypassing the spinal cord in order to activate them directly.

NeuroMoves exercise physiologist Sam Mitchell with the RT300 Functional Electrical Stimulation Ergometer that assists with arm and leg rehabilitation for patients with illnesses such as paraplegia, quadriplegia and stroke.

The RT 300 and other equipment in the facility were officially unveiled on July 21st by the key partners in this latest NeuroMoves service, the first of its kind in regional Australia.

Coming together to celebrate and meet some highly appreciative patients were Peter Perry, chief executive of Spinal Cord Injuries Australia (SCIA), which manages NeuroMoves, Southern Cross University’s Vice-President Global, Chris Patton, Marlene Assim, SCU Health Clinic Manager, and Graham Batten, Executive Officer of Newcastle Permanent Charitable Foundation, which has granted $88,000 to fit out the facility.

“People living with a disability in regional areas should have access to the same high quality equipment and services available to those living in the city,” Mr Batten said.

Previously, as Mr Perry noted, people with spinal cord injuries, neurological conditions and other physical disabilities had to fly to Sydney or travel north for this kind of specialised care. He expects that the roll-out of the NDIS will significantly increase the facility’s usage.

Mr Batten congratulated SCIA for bringing NeuroMoves to Lismore, and praised SCU for supporting this important community partnership.

“It’s bound to make a significant difference and help to improve the fitness, mental health and general wellbeing of local people living with a physical disability,” he added.

Maclean Hospital's new rehab opens

Maclean District Hospital's new Rehabilitation Unit was officially opened on 2 June 2017 by the Federal MP for Page Kevin Hogan.

The Unit has 10-new purpose-built beds and will provide coordinated care from a multidisciplinary team that includes medical, nursing, physiotherapy, occupational therapy, speech pathology and social work.

"Previously, the nearest rehabilitation facilities were located in Coffs Harbour and Ballina, so this is a fantastic investment in the health of our growing population in the Clarence community," Mr Hogan said.

The new unit offers single and double rooms, all with en-suite facilities. It also includes a fully equipped therapy gym, spacious dining room and kitchen for group activities and social interaction.

The Rehabilitation Unit adjoins a courtyard garden designed to provide patients with opportunities to practice regaining normal functions in a domestic setting.

Patients at the Unit receive individualised rehabilitation programs designed to provide them with tailored therapy to suit their particular needs.

State MP for Clarence, Chris Gulaptis, added that the rehab unit enables residents of the Clarence Valley to receive rehabilitation treatments without leaving the area.

"This fantastic facility allows patients in the Clarence Valley to access first class therapies right here on their doorstep."

New study finds GP accessibility a major issue

A detailed study of the availability of GP care in northern NSW* has found that while the area has high rates of chronic illness and an ageing population, there is limited access to an affordable, same-day GP appointment.

The study found that less than half of potential new patients would be able to see a doctor on the same day if they rang the practice that morning. There would be even less chance if their requirement was to access a female GP, according to the study 'Actual availability of appointments at general practices in regional New South Wales, Australia', published in the latest issue of the journal Australian Family Physician.

Improving the availability of primary healthcare services would benefit both patients and the public health budget by reducing the "non-urgent use of emergency department services".

Working from a list provided by the North Coast Primary Health Network the researchers engaged a professional interviewer to contact all 184 medical practices in 12 local government areas ranging from Tweed Heads to Coffs Harbour, including inland locations such as Kyogle, Tenterfield and Bellingen.

Of these, 22 were excluded because they provided exclusively specialised services, including Aboriginal health, skin clinics, women's health and headspace. The final sample size was 162, and these were contacted by telephone in March 2016.

The methodology followed that of a 'secret shopper' study conducted previously in Victoria. Here, this involved a hypothetical patient scenario designed to reflect a presentation frequently encountered in general practice. It was consistent with a category 4 or 5 classification on the Australasian Triage Scale, if the patient were to present to an ED.

If required, the interviewer posed as the relative of a woman aged 60 years who recently moved to the area, had been experiencing mild abdominal pain over the past few days and was covered by the Medicare Benefits Schedule (MBS) but not eligible for any other concessions.

The primary focus was to determine the likelihood of a same-day appointment with any of the practice's GP. The other questions related to the availability of a female GP on the same day, the bulk billing status, and if bulk billing were not available, what would be the associated out-of-pocket costs for the appointment.

The results showed that the availability of a same-day appointment for new patients across the region was 47.5 per cent, increasing to 57.4 per cent for an appointment within 48 hours of the call, almost 60 per cent within three days, and 70 per cent within 10–15 days.

They report that one-in-five practices could not offer an appointment at all (also finding that only one-in-five practices bulk-billed). The main reasons given for no available appointments were that the practice was not taking new patients or was fully booked.

"Some of the clinics advised that new patients were required to attend a longer consultation, which may have reduced the availability of a same-day appointment and increased costs," the researchers noted.

The location showing the least chance of a same-day appointment was Nambucca (11.1 percent), and the highest was Port Macquarie-Hastings (63 per cent).

Northern Rivers figures were highest in Byron Shire (60 per cent), with Lismore at 50 per cent likelihood, Ballina at 33.3 per cent, and Richmond Valley at 28.6 per cent.

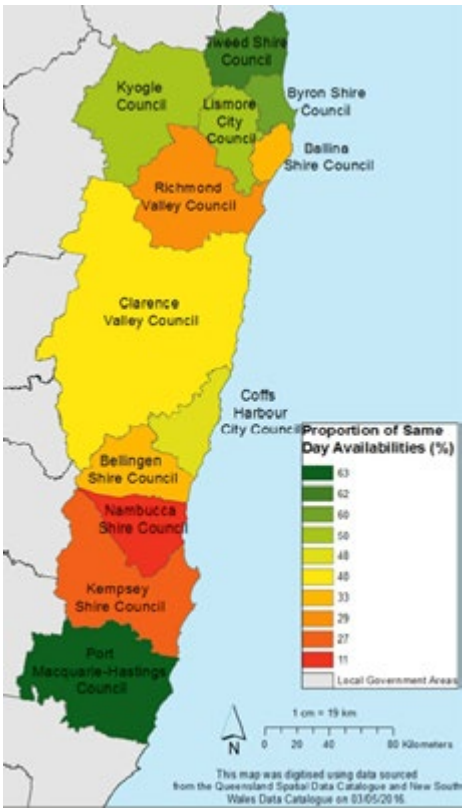
With an average bulk-billing rate of 20.7 per cent, the North Coast fell considerably below the national average of 83.7 per cent (according to the MBS). The Northern Rivers' highest bulk-billing rate was in Lismore (21.4 per cent), followed by Byron at 6.57 per cent. While Ballina and the Richmond Valley registered 0.0 per cent, 50 per cent of Kyogle-Tenterfield practices bulk-billed.

The average out-of-pocket payment by patients was $30.00, slightly lower than the state and national averages.

The Melbourne study that sought the same information found that 75 per cent of local practices bulk-billed.

The researchers concluded that areas of northern NSW with longer waiting times could be targeted for additional attention from policy makers, such as GP workforce enhancement or alternative healthcare models that may increase access to primary healthcare.

"Health services reform is part of the New South Wales Rural Health Plan, which aims to improve access to health services as close to home as possible. Despite the fact that



Map showing Same Day Availability (Permission for use by RACGP see footnote 2)

the New South Wales government has increased investment in rural health services over the past few years, findings from this study suggest further improvements are required to facilitate easier access to primary healthcare for regional areas, particularly for first-time patients," they said.

"With 80% of people who recently attended an emergency department citing the lack of GP availability when needed as the major reason for attending, there is a possibility that increasing GP availability would decrease attendance to emergency departments.

"Indeed, in 2014-15, eight of the 12 local government areas in this study had higher than state average hospitalisations rates. Further research is required to identify how patients make decisions about whether they would attend general practice or emergency department for non-urgent conditions."

* Bradbury, J., Nancarrow, S.A., Avila, C., Pit S.W., Potts, R., Doran, F., Freed, G. (2017). Actual availability of appointments at general practices in regional New South Wales, Australia Australian Family Physician. 46(5), 2017. 321-324.

BreastScreen GP Electronic Messaging Project

After many years of complaints from GPs about the problems associated with paper based reporting, the North Coast BreastScreen Service is to trial an electronic system.

According to Nick Astone, Patient Clinical Information Manager for BreastScreen NSW North Coast, the next version of their information system will contain a GP electronic messaging facility.

Faster processing of abnormal and equivocal reports will reduce both the psychological and physical morbidity of breast screening and will be welcomed by patients and GPs alike.

Currently there are 12 practices in the Hunter region undertaking a pre-release pilot that is testing the workflow issues of the electronic format. Next year the new software will be trialled and practices on the North Coast are eligible to participate.

A web portal is being developed to facilitate the recruitment of practices for the beta release.

The BreastScreen reports will be delivered to practices through their existing secure messaging providers, Medical Objects and Healthlink and will be in digital not graphic format.

Providing the pilot is successful, it is anticipated that the electronic reporting facility will be rolled out to the rest of the State in late 2018.

A similar streamlining of bowel cancer screening reporting is currently underway on the North Coast with an increasing number of the National Bowel Cancer Screening Program reports being delivered electronically.

Setting up systems for the electronic exchange of patient information has been a slow and painful process but general practice welcomes the progress that is being made in these important areas of cancer screening.

MP helps confirm NDIS checks are billable

At the behest of a local practice, the Federal MP for Page, Kevin Hogan, has resolved contradictory government advice about whether medical practitioners can bill Medicare for providing medical reports for NDIS clients.

Mr Hogan (and Health Minister, Greg Hunt) was contacted in early June by the Practice Manager of the Lismore GP Super Clinic, Terese Forzan, seeking clarification on whether GPs could "bill Medicare for a consult item for the time taken to complete a National Disability Insurance Agency (NDIS) form."

Ms Forzan added, "Medicare has advised its Directions made under subsection 19(5) of the Health Insurance Act do not cover a consult item for the completion of a NDIS form."

Calling this a matter of "national importance', she said the situation was confusing to local doctors, and clear advice from the ministerial level was required.

A written response from the Department of Human Services Health Support & Business Services Division passed the parcel to another Department, advising that, "Policy for the National Disability Insurance Scheme (NDIS) and its administration, including medical reports to determine eligibility under the NDIS, is the responsibility of the Department of Social Services (DSS)."

> *"It is reasonable to expect that doctors will perform an examination of some description..." – Federal Dept of Health*

It added, "To date, there are no subsection 19(5) Directions in place which would allow Medicare benefits for a consultation to complete a NDIS form."

Dissatisfied with this response, Ms Forzan contacted Mr Hogan again, seeking further information.

The MP has since replied, advising, "I can confirm that the time taken by medical practitioners to complete a medical report for the purposes of the NDIS may be claimed under a Medicare item when the report is completed as part of a consultation.

"When a treating doctor's report is completed without an associated consultation and without the customer present, a Medicare rebate is not payable... In completing a treating doctor's report, it is reasonable to expect that doctors will perform an examination of some description to assess or confirm the person's current medical condition. This examination requires a consultation.

"It is the doctor's discretion to choose the Medicare item number relevant to the level of consultation and to the area of medicine in which s/he practices (be that as a General Practitioner, psychiatrist, paediatrician or another specialist). This means that doctors claim the Medicare Schedule item number that most appropriately reflects the nature of the consultation.

"It is for the doctor providing the service to judge the level of complexity and bill accordingly...."

Griping about the Flu

Statistics from NSW Health have confirmed the clinical impression of many North Coast GPs that the flu season has hit early this year. They report the predominant strain is influenza A (H3N2) but levels of influenza B have also increased in recent weeks.

While the symptoms of influenza are similar to many viral infections with sore throat, cough, nasal discharge and blockage, the high temperatures, lethargy and myalgia of influenza that last for four or five days have been common presentations in recent weeks.

The availability of PCR testing for viral antigens on nasal and throat swabs has been a significant advance in the rapid diagnosis of respiratory tract infections. However the clinical utility of this testing is lessened as the prevalence of influenza rises in the general community.

Antiviral treatment in the form of oseltamivir (Tamiflu) and zanamivir (Relenza) have been available for some years. These agents have limited value shortening the period of symptoms by 24 hours. This is mainly of clinical utility to patients with significant risk for progression to influenza's life threatening complications. The high cost of these medications may be justified in patients with COPD and congestive heart failure. In such patients the medication should be started at the time of diagnosis and not await laboratory confirmation.

Data from Sullivan Nicolaides pathology confirms the rapid rise of influenza in southern Queensland. Fortunately, NSW Health reports the recent strains are covered by the current vaccination, so patients, particularly the elderly at risk, can still benefit from vaccination this late in the season.

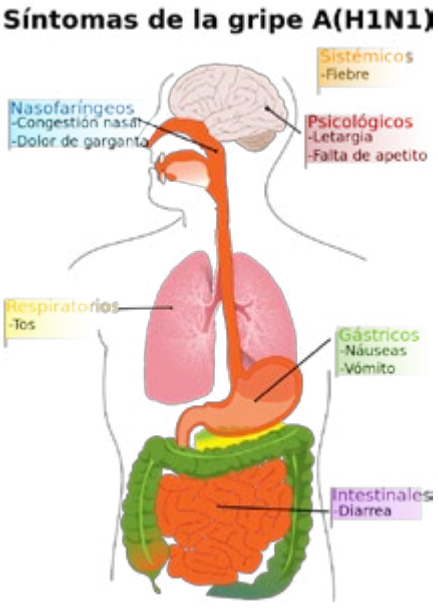


Image courtesy CC-by-SA

Embrace
Exercise Physiology.

"USE EXERCISE AS MEDICINE"
AN EVIDENCE BASED APPROACH

"At Embrace we are Home Care Package and NDIS friendly"

Our exercise physiologists are ready to see patients under HCP and NDIS - this can be at home or in one of our clinics.

We help people stay healthy and independent.

SERVICING AREAS
Tweed Heads, Byron Bay, Ballina, Lennox Head, Ocean Shores, Lismore, Goonellabah, Casino, Evans Head

Refer to an Embrace Exercise Physiologist
1300 212 555

Fax: 0266 244071
info@embraceep.com.au
Instagram: embrace_exercise_physiology
www.embraceep.com.au

Radiation oncology specialist at Byron Bay

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

Professor David Christie (Radiation Oncologist) attends the Byron Bay clinic once every six weeks and has extensive experience in treating all major cancer types including Prostate, Head and Neck, Lung, Breast, Colorectal, and Skin malignancies.

Dr Steven Stylian (Medical Oncologist) attends the centre every 3 weeks, ensuring a multi-disciplinary approach.

For further information about the 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

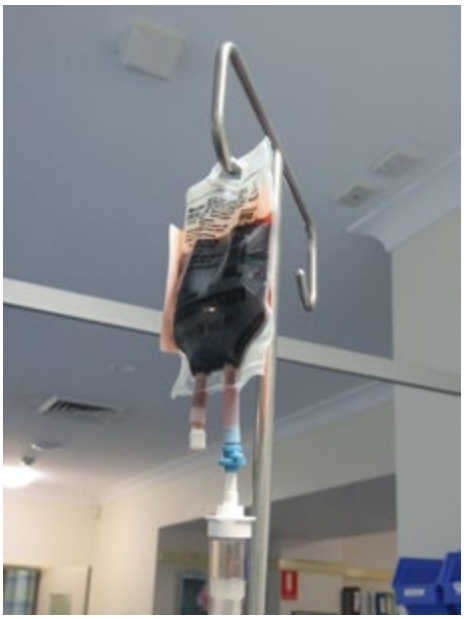
Genesis Cancer Care Queensland

GenesisCare

Ironing for North Coast General Practices

by Beverley Hiles
Clinical Nurse Consultant for
Blood and Blood Products

The National Patient Blood Management Collaborative (NPBMC) conducted by the Australian Commission on Safety and Quality in Health Care (ACSQHC) concluded in March 2017.

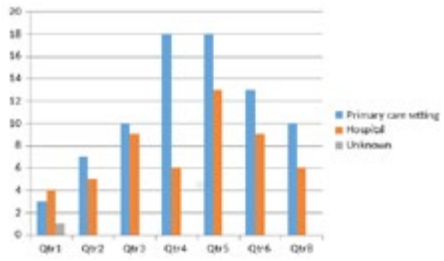


For the past two years Lismore Base Hospital, St Vincent's Private Hospital and the North Coast Primary Health Network have been involved in the NPBMC, working towards identifying and managing pre-operative anaemia and/or iron deficiency in patients preparing for major elective bowel, gynaecological and joint replacement surgery.

With a particular aim of avoiding blood transfusion, local NPBMC teams concentrated on engaging GPs in the Primary Health Network to optimise patients' iron and haemoglobin status prior to surgery.

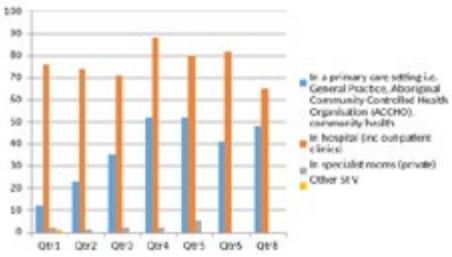
Although the Collaborative has come to a close, local data collection and further work in other surgical streams is ongoing. We aim to optimise pre-operative care for patients undergoing all types of major surgery by complying with the ACSQHC National Health Care Accreditation Standards.

As shown below, over the course of the Collaborative pre-operative iron deficiency assessment has markedly increased in both the primary and secondary sectors.



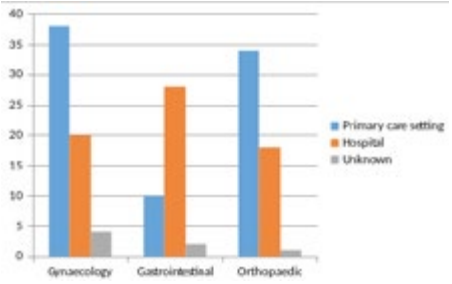
Site of pre-operative assessment for iron deficiency

Primary care led the way in pre-operative iron deficiency management, with the numbers rising steadily in the first half of the Collaborative.



Site where iron deficiency was managed

When analysed by surgical cohort, iron deficiency management in the gynaecological and orthopaedic streams was well managed in primary care.



Site where iron deficiency was managed (by surgical stream)

Conversely, hospital services managed 70% of identified iron deficiency in patients undergoing gastrointestinal surgery. This may be due to the often short time to surgery after a colonoscopic diagnosis that requires surgical intervention.

In an effort to address these findings, a management point has been added in the Mid and North Coast NSW, Health Pathways: Bowel Cancer Symptoms (Management Point 2).

"If iron deficiency is identified, consider commencing iron replacement, as this will not affect results of colonoscopy, and will lead to improved outcomes if surgery is required. If rapid iron replacement is required, see Iron Infusion."

Hospital services have limited capacity to provide iron infusions. Undertaking iron infusions in general practice contributes to improved care and less waste in the hospital system.

The Northern NSW Local Health District is able to assist general practices with implementing iron infusions in their surgeries. Local Clinical Nurse Consultant for Blood and Blood Products, Beverley Hiles, is now available for onsite general practice visits.

Visits can be organised to minimise disruption to practitioners' schedules and are tailored to the particular needs identified by the practice. Topics for practices to consider include:

- evidence based practice protocols for iron administration
- iron management guidelines for staff
- patient information pamphlets and consent sheets
- iron studies interpretation guides
- cannulation training

An excellent resource for general practitioners is Dr Pradeep Jayasuriya's informative discussion on iron deficiency at the recent Adelaide Iron Symposium: From Primary to Tertiary Care, June 3rd 2017 where he shared his experience of setting up iron infusions in general practice.

General practices interested in undertaking or improving their iron administration capacity can contact Beverly Hiles at Beverly.Hiles@ncahs.health.nsw.gov.au or on (02)6620 7422.

UOW Medical students abroad

As part of their 4th year of training UOW medical students do a clinical elective to broaden their experience before graduation. Some choose an overseas placement.

Aiasha Saikal and Trish Griffiths (*pictured*), who spent their final year in Goonellabah and Mudgee respectively, have recently spent a challenging time at the very large Chris Hani Baragwanath Hospital in Johannesburg, South Africa.

Here they saw lots of major trauma with stabbings, gunshot wounds and full thickness burns. It was overwhelming at times hearing the stories and seeing just how much suffering these patients endured. However they appreciated the experience and gained a lot of procedural skill including the insertion of chest drains.

Following this demanding clinical experience they were pleased to then be able to relax on safari in the Okavango Delta, Botswana.

Costa Rica is Pura Vida, no worries

by Dr Michael Leslie

Dr Michael Leslie meets a Costa Rican local.

Think again if you imagine this Central American nation to be another lawless hell-hole awash in drugs.The people of Costa Rica ('Rich Coast'), known as 'Ticos', live by the code of Pura Vida, an infectious mixture of "no worries" and "stay cool", which results in a cohesive society full of optimism.

It has had public schools for all since the 1880s, free healthcare and civilised labour laws, major drivers of this wonderful place.

My wife, my sister-in-law and I joined nine others on a two-week tour through the country with our guide Xander and his trusty sidekick Pappy piloting the bus. For those readers of a certain age, these two were very reminiscent of Pancho and the Cisco Kid.

San Jose the capital sits in the elevated Central Valley surrounded by active volcanoes. After the spectacular flight in, we found the main road into the city was being repaired so our taxi driver took us by the 'scenic' route, a bit daunting, with dusty shanties and much barbed wire.

Blue Crowned Motmot bird, photo by Pat Leslie, taken near La Fortuna , Costa Rica

Back on the main drag however all looked fine - car showrooms, universities and so on. At our hotel we were welcomed to an old converted mansion within walking distance of the town centre, with lots of modern shops and street stalls, but no hassling.

Lottery tickets are big with a seller about every twenty metres adding to the din. My five foot–ish wife likes Spanish countries as she has no trouble seeing over the crowd.

The highlights are the central fort, now the National Museum, with the army having been abolished after a failed coup in 1948, the Native American museum and the vibrant street scene.

The bus trip covered the central third of the country, first north into the agricultural areas then east into the central rainforest volcano area and cloud forest, then south to the Pacific coast.

We stayed on an agricultural commune learning some cooking and cocktail making skills and joining the locals for a dance after a display by the children.

All dirt roads and quite a way off the tar but the mobile phones still worked. The family we stayed with had no English and we little Spanish but photos of our family and Alstonville soon broke the ice.

The next week was a blur of different landforms and a dazzling array of wildlife. Colored birds of all sorts, varieties of monkeys, sloths, caimans and crocodiles, amazing coloured lizards, armadillos and even a hedgehog.

Activities ranged from swimming in splash pools of mighty waterfalls to zip lining through the canopy to a leisurely soak in the hot volcanic springs. Xander even found a member of the exotic Quetzal bird family in the forest.

After the word on this got out, we were overrun by a herd of Japanese twitchers, travelling the globe in search of avian delights.

We moved from coffee and chocolate growing volcanic slopes to the coast with its languid, muddy and crocodile infested rivers. About 30 km south of one of these rivers we stayed at Quespos near Manuel Antonio National Park. Straight into the surf we went - it looked pretty croc free and there were plenty of people in the water.

After a nice swim in water about twenty eight degrees we had a stroll to the southern end of the beach where there was a mangrove lined creek with a sign warning of the presence of crocodiles! Apparently they don't swim as well as our version of these deadly critters..

Back to the Hotel La Rosa Del Paseo, a place I recommend highly, another day in San Jose (is that a song title?), a Sunday with thousands of people in the streets and then home.

Costa Rica is a fabulous society in a stunning landscape... Pura Vida.

p4$$W0rd

by Dr David Guest

"Please create a password for your account. Enter the new password in the fields below:

New Password _____Superdoc_____

New Password (verify) _____Superdoc_____

Bad Password Choice: The password you have chosen is not a good choice, because it is based on a dictionary word.

New Password _____Sup3rdoc_____

New Password (verify) _____Sup3rdoc_____

The password you provided was not a good password. A good password must contain all of the following: upper case letter, lower case letter, number, non-alphanumeric character, be at least 7 characters long.

New Password _____Sup3r$D0C_____

New Password (verify) _____Sup3r$DOC_____

The passwords you entered did not match."

Ugghhh! Passwords are the bane of our lives. Creating them is difficult enough. Remembering 50 of them for all your websites is an impossible task. Most people have three or four which they recycle.

This is not a good practice. If a hacker cracks your password, they gain access to many of your online accounts. You may not care particularly if they are unimportant sites, but access to these "disposable" accounts provides a gateway for hackers to escalate access to your other online services.

Hackers can often convince customer support to reset security questions by using the small amounts of data gleaned from compromised accounts and from your publicly accessible data. (Note: Never use your date of birth or dog's name in your password.)

Such compromises are possible even if your own online security is strong. There are almost daily reports of companies, both large and small, having their data stolen.

Some companies delegate the authentication of their users to social media services such as Facebook, Twitter and others. Instead of creating a new username and password, you are redirected to your preferred service where you logon. If successful, you are transferred back to the original web site with an authentication token that is trusted by all parties.

While this may be an improvement, it is not perfect. It is prone to a "man in the middle" attack and even these online authentication providers can be hacked. In 2013 over one billion Yahoo's customers' accounts were stolen.

What to do?

One solution is to write every password down in a book. Offline security keeps passwords safe from hackers but not from local thieves. It is also not very practical when you are away from your home computer, and woe betide you if you lose your book.

Another solution is to keep all your passwords and other secure data in an encrypted online file. It is best to put the file on a host that requires you to authenticate to log on. Companies such as Dropbox provide this service. However, your password file needs to be encrypted to stop the host's employees reading it. A different password is best for this step.

This is a good solution but not very convenient and proves to be too much of an effort for most users. In the battle between security and convenience, security usually loses.

Most browsers now offer the facility to save passwords. The better ones encrypt the data and store it on the web making it available wherever and whenever you log into your account. They can even fill in online forms for you.

While these systems make a concerted effort at securing data, they will usually have a back door to allow access by law enforcement agencies. By definition an open backdoor is not secure.

Alternatively, there are a large number of web based products designed to make it easier to be secure online. The more sophisticated ones can generate long passwords, store financial data and restrict activity based on your device or geographic location. They can be used on mobile phones, tablets and desktops and will sync across operating systems and browsers.

Most permit, and recommend, using two factor authentication. The first factor is your username / password combination. The second factor is a physical device that generates a password that changes every thirty seconds. In the past these second factors authenticators were small dongles that you would keep on your key ring. However, with the ubiquity of smart phones a mobile app is now more commonly used.

An alternative second factor is a SMS code. This is still popular with banks but with better and cheaper solutions now available this is being deprecated by many online sites.

The real value of two factor authentication is that even if your main password is compromised, hackers still cannot access your account without the second factor.

Conclusion

The web is a vastly more interesting, but also a more hostile, place than it was 25 years ago. Few can ignore it and the risks can be managed with a cautious approach to browsing and unsolicited emails, and by using a password manager with two factor authentication.

Last Writes - Book Review

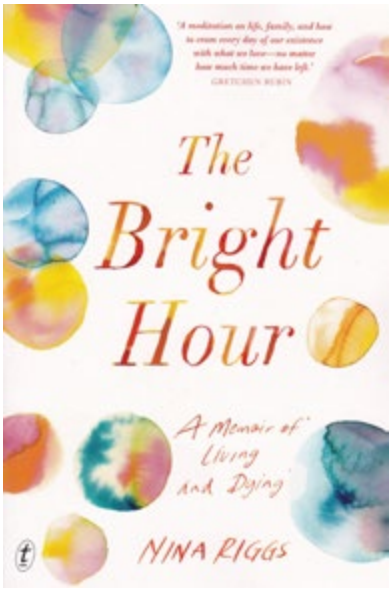
Reviewed by Robin Osborne

The Bright Hour

A Memoir of Living and Dying

Nina Riggs

Text 310pp $29.99



The last three books to hit my desk from Melbourne based Text Publishing have concerned living and dying, two of them by female authors, one Australian (Cory Taylor), the other American (Nina Riggs), who both passed on soon after completing their manuscripts.

The third, *Thirty Days - A Journey to the End of Love*, is by Jewish-Australian author Mark Raphael Baker (The Fiftieth Gate) who has written beautifully about his reationship with wife Kerryn and her death of a rare bowel cancer relatively soon after diagnosis.

It took just thirty days, the prescribed Jewish mourning period for a spouse, for him to complete the memoir of a married life that had consumed three happy decades of the couple's life. His earlier book, an account of his parents' Holocaust experiences, had taken many years to complete.

Sadly, a similar time-frame from diagnosis to death applied to Nina Riggs, an acclaimed writer who lived in Greensboro, North Carolina with husband John, their two ever-curious young sons, and their dogs.

Her tale takes us deep into the heart of the family, sharing their meals, their reunions and vacations, and the stories of their relatives, including her famous forebear, writer Ralph Waldo Emerson, whose thoughts she references frequently.

While we're encouraged not to judge books by their covers, I must confess that *The Bright Hour*'s didn't quite do it for me, the clever but pastel design being more akin to a self-help book than one charting a life well lived, and a death journey intelligently examined.

I note this reluctantly as an acknowledgment by the author's husband John Duberstein makes clear that Riggs liked it a lot - "Nina wanted to thank Samantha Hahn for the fantastic cover art..."

Certainly this is a book as much about, perhaps even more about, living than dying, but it is underpinned by the finality of death, and the cover image sits in contrast to the covers of *Thirty Days* and the late Cory Taylor's much praised *Dying - a Memoir*, striking in their eclipse-like simplicity. Both were designed by Text's W.H .Chong.

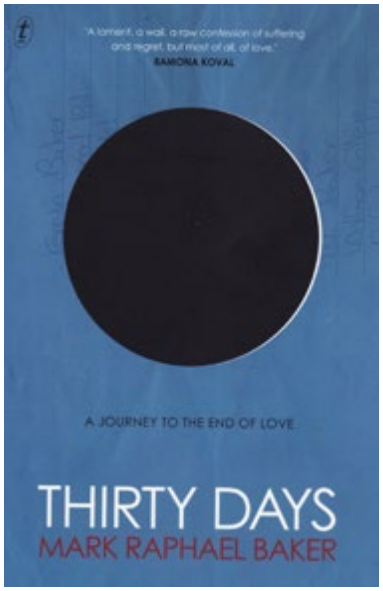
Appropriately, however, Riggs' title and its cover are inspired by her favourite time of day, early dawn, and it seemed fitting, as husband John puts it, that she would die just before daybreak, in February this year, at the age of 39.

While tragic, as is any young death, this book is a wonderful memoir of a well educated American family - that is stricken by ill health (Riggs' mother had died of cancer not long before her own terminal diagnosis).

Yet there are memories of social occasions and times well spent, both before and after she and John had children. It is often laugh-out-loud, my favourite being her description of a dinner at an Argentinian steak house in Paris, a city where they had lived pre-children. The meat, she notes, was cooked sanglant - "as they say: bloody... more marbled than the palace at Versailles."

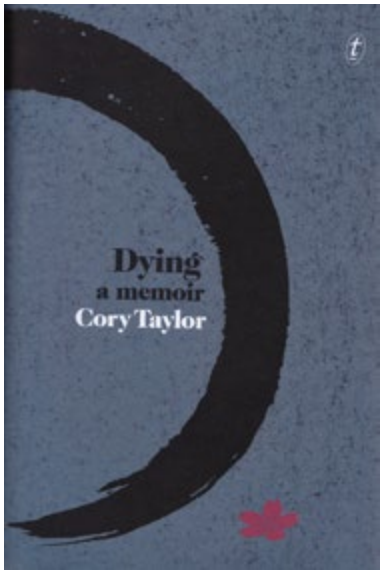
Riggs has a fine facility with words, and amidst her enjoyable recollections she manages to chart the cancer journey with dexterity.

"On the latest mammogram images, it looks like you're staring down from an airplane at night. The two tumours are lit-up cities - say Greensboro and Winston-Salem. And the four-centimetre stretch between them is Interstate 40, illuminated by headlights. We won't know exactly how trafficky I-40 is until the surgeon gets in there."



Later, with tumours in her hips and pelvis, she needs to use a cane, choosing one in dark blue with a "comfy rubber grip and a floral pattern that looks like bathroom wallpaper from the 1960s. I'm pretending that I'm starting a hip new craze... like vaping or lumberjack beards or bone broth. Canes: the new frontier in walking... Extra virgin, cold-pressed walking."

This is a wonderful memoir that deserves to be read by the living and dying everywhere.



Gold Coast PRIVATE HOSPITAL INTRODUCES

NOW PRACTICING AT TWEED DAY SURGERY

Dr. Erlich Sem

BMBS, MD, FRANZCOG (QLD)

Advanced Laparoscopic Surgeon, Obstetrician and Gynaecologist

Dr. Sem specialises in:

- Total Laparoscopic/ Robotic Hysterectomy
- Laparoscopic Myomectomy
- Laparoscopic Removal of Endometriosis with preservation of pelvic organs
- Laparoscopic Ovarian Cystectomy / Oophorectomy
- Laparoscopic Division of Adhesion
- Endometrial Ablation (Novasure)
- Pelvic Organ Prolapse Repair
- Office Gynecology & Colposcopy

Phone: (07) 5530 0770 ***(for all appointments)***
Fax: (07) 3905 1881

Gold Coast Private Hospital
Suite 18, Level 1,
14 Hill Street (off Parklands Drive)
Southport QLD 4215

Tweed Day Surgery
Suite 4, 38-44 Boyd Street,
Tweed Heads NSW 2485

Dr. Lee (Liqun) Yang

M.D., Ph.D., Master of Surgery,
MBBS, FRACS

Neurourgeon and Spine Surgeon

Dr. Yang specialises in:

- Keyhole spine surgery
- Brain aneurysm
- Brain tumour
- Brain bypass
- Brain AVM
- DAVF
- Degenerative spinal disease
- Spinal tumour
- Spinal trauma
- Spinal infection
- Spinal deformity

Phone: (07) 5530 0770 ***(for all appointments)***
Fax: (07) 5530 0687

Gold Coast Private Specialist Suites
Gold Coast Private Hospital
Ground Floor
14 Hill Street (off Parklands Drive)
Southport QLD 4215