GPSpeak

Journal of Northern Rivers General Practice Network

IN THIS ISSUE

PLUS

Travels in Yoga-land
Theatre, music, books, and more

February - March 2014

Editor's View

by Dr David Guest

Like so many of the ED staff in our local hospitals – and those throughout Australia - Bangalow GP Graham Truswell, knows only too well the devastating long term consequences of alcohol fuelled violence. In his contribution abut the "Last Drinks @ 12" campaign for Byron Bay, he details the statistics and issues, and posits some solutions.

The recent acknowledgement of this issue by NSW Premier Barry O'Farrell is a major triumph for the campaign that continues to be conducted both locally and in Sydney, and is the first time in decades that there has been a response from either political party to the problem. From the start of March, the recently enacted NSW legislation will enforce last drinks at 3.00 am, a 1.30 am lockout and the closure of bottle shops at 10.00 p.m. in the Sydney CBD, Darling Harbour and Kings Cross.

The "coward's punch" that recently killed young Daniel Christie in the Cross has made alcohol violence a mainstream issue. Fears that the new legislation will result in a prohibition-style rebound in illicit alcohol sales and consumption are speculative at best. Nevertheless, legislation is only one component of reducing alcohol fuelled violence.

A continuing education campaign and improved infrastructure will be necessary to reduce the problem in Byron Bay where the alcohol sale restrictions detailed above have been in place for some time.

Byron has a vibrant culture but neither publicans, nor councillors, nor the general community can ignore the increased risk of sexual assault and bashings in this otherwise idyllic corner of Australia.

A public education campaign will also be necessary to increase the use of long acting reversible contraceptives (LARCs) in Australia.

Last year in the MJA Black, Bateson and Harvey argued for this (cont p3)

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Editor's View... cont from p2

form of contraception to reduce the risk of unwanted pregnancy for women, particularly at either end of their reproductive lives. In this issue of GPSpeak our colleague Andrew Binns describes the Australian situation, and a recent Health Report expands on the issue.

Creating awareness and demand for this reliable and safe form of contraception will count for naught if we do not also provide the facilities to obtain LARCs. In the first instance we need to collate and disseminate the information about which GPs and Family Planning Clinics are inserting LARCs.

However, we also need to increase the numbers of GPs doing insertions. There has been interest in forming a special interest group to help train other GPs interested in acquiring these skills. Several GPs in our area are qualified to teach IUCD insertion.

This issue also enables local vascular surgeon, Dr Deepak Williams, to present an overview of leg ulcers. We are planning further articles on the advances in this rapidly changing branch of medicine..

Dr Rohit Singh, from the North Coast Radiology Group, outlines the new PBS indications for GP-instigated adult MRI. He also reminds us that assistance in radiology investigation is readily available to NRGPN members via the referrer hot lines.

I would like to remind readers that nearly all the articles that appear in the PDF of GPSpeak can also be found on the website. The search facility on the site is very sophisticated and readers looking for a particular article should be able to find it with only one or two search terms.

I would like to congratulate Tim Allsopp on his recent appointment as CEO of St Vincent's Hospital, Lismore. He has taken over from Bob Walsh whom we wish well in his new role in the Diocese where he will be responsible for medical projects like the Theatre redevelopment at SVH and the integration of Ozanam Villa into Aged Care operations.

Lastly, special congratulations to Chris Crawford of the NNSW LHD on his Public Service Medal and Juriaan Beek for his Medal of the Order of Australia. Both have given years of fine service to the health and wellbeing of Northern Rivers residents, and these awards are an apt acknowledgement of their commitment.

David Guest, NRGPN Editor and Chair

Contents

Bad Moon Rising - Last Drinks @ 12

by Dr Graham Truswell, General Practitioner

Don't go around tonight,
Well, it's bound to take your life,
There's a bad moon on the rise.
- Bad Moon Rising, Credence Clearwater Revival

The tolerant, permissive, easy going reputation of Byron Bay is being confronted head on by a drinking culture that sees a laid back attitude as a green light to trash the town, trash themselves and frequently trash others around them

After New Years Eve 2012, large numbers of residents spent the subsequent days cleaning up graffiti, vomit, bottles and garbage, and the Byron Council spent $50,000, the community met to vent their frustration.

Byron Shire's Statistics

Local police told meetings of the seriousness of the problem. Damning figures put the problem into perspective.

1. The number of visitors to Byron Shire has not altered over the last decade. The number of families or groups staying for a week has halved while the number of younger visitors staying overnight or weekends has doubled

2. Byron Bay had the 3rd worst rate of 'Alcohol Related, non-Domestic Assault' in NSW from 154 local government areas, figures are similar for 'Resist/Hinder Police' and 'Offensive conduct'. 'Alcohol Related non-Domestic Assault' rate is 19 times the State average

3. 84% of assaults are linked with 5 licensed alcohol venues, the late night venues open until 03.00

4. 81% of assaults in Byron are alcohol related, compared to a State average of 41%

5. 1 in 87 vehicles stopped were caught drink driving compared to a State average of 1 in 244

6. Sexual assault rate in Byron 15 times the State average

And yet, Byron has a lower than State average rate of non-alcohol domestic assault.

The Group, Last Drinks at 12 formed to look at ways that might reverse the trend. We spoke to experts, listened to locals and researched the evidence. Many issues became clear, some related to Byron Bay, some national and some global.

Byron's issues

1. A culture of licensed venues encouraging behaviour that promotes binge drinking, dancing on tables, wet T shirt competitions, failing to comply with responsible sale of alcohol - loud music, dark venues, etc.

2. Backpacker hostel beds have increased to over 6,000; transport is laid on to take patrons to clubs; hostels use licensed venues t o 'babysit' patrons to keep noisy residents out of their rooms and large numbers of 18-29 year old tourists attract young patrons from outlying areas.

3. The Byron Drinking culture increases underage binge drinking.

4. The community tends to pay the cost of clearing up, not the licensees.

5. Byron is a common venue for schoolies weeks, strongly associated with binge drinking. (cont p5)

Last Drinks in Byron Bay - cont from p4

6. 30% of violence occurs inside venues, 70% outside in the street or public spaces.

7. Byron has a high density of alcohol venues, bottle shops and venues selling alcohol in a small CBD.

8. Byron has poor transport options.

9. In 2012, police supplied many more officers to deal with the alcohol problem; alcohol related arrests increased.

10. Police collected (BOCSAR) data is comprehensive, but nearly all hospitals in Australia do not collect health data related to alcohol.

11. All groups in Byron Bay agree that the alcohol related problem needs to be attend to and reduced.

Byron's Solutions

Our research and advice has lead us to the conclusion that the measures that have the greatest impact on reducing alcohol related violence at least cost are

1. Random Breath Testing of drivers.

2. Bringing forward the last sale of alcohol by venues and bottle shops.

3. Increasing the price of alcohol.

4. Increased alcohol taxation especially of cheap high alcohol drinks.

5. Reducing the consumption of high alcohol 'shots'.

6. Reducing the consumption of 'energy drinks'.

7. Reducing 'pre-loading / pre-dinking before entering alcohol premises.

8. Improved policing of the responsible sale of alcohol.

9. The introduction of a 'precinct liquor accord' to increase police and the communities involvement and oversight of the alcohol industry.

10. Preventing the introduction of new late licences.

11. Introducing mandatory 'lockouts', stoping drink hoarding, cessation of sale of 'shots' and energy drinks.

12. Closer supervision of all points of sale of alcohol to reduce underage access to alcohol.

The main thrust of our community action has been attempting to bring forward the closing time of late night venues. National and international research shows that for each hour a venue is closed earlier, alcohol violence reduces by 16%. Hence as our name indicates, closing venues at 12 alone would reduce the problem by over 50%

The Byron Campaign

Our current approach is to educate the community, enlist supporters, approach all community groups to explain the campaign and obtain signed letters of support, seek legal advice on closing venues earlier, issue frequent media articles and responses to news in the media and lobby politicians local and State. We have managed to start collecting data on alcohol related presentations to the Byron Bay Hospital. We have made representations to the NSW State enquiry into alcohol and youth drinking. We have lobbied senior members of the State government and put pressure on Barry O'Farrell to help bring about changes to alcohol legislation.

We see the issue as a long campaign with the objective of turning Byron Bay from very near the worst local government for alcohol related harms, to one of the best, in the hopes of restoring Byron to the tolerant, easy going, permissive community it once was.

Australian women need better access to long acting reversible contraceptives (LARCs)

A recent paper published in the MJA (1) discussed concerns expressed at the National Sexual and Reproductive Health Conference in Nov 2012 relating to the high rate of unintended pregnancies and associated costs in Australia. Compared with countries in Northern Europe we have a relatively high rate of unintended pregnancy and abortion (19.7 per 1000 women aged 15-44 years compared with 17 per 1000 in Northern Europe).

At the same time we have a low uptake of the most effective methods of contraception namely LARCs used by only 6% of women using contraception versus 14.8% in northern Europe. LARCs include 3 monthly injections (depot medoxyprogesterone acetate); a progestogen-only (etonogestrel) subdermal implant with duration of action up to 3 years; and IUDs - the hormonal levonorgestrel device effective for 5 years or copper devices effective up to 10 years.

(cont p7)

LARCs - (cont from p6)

It seems from US studies that adolescents and young women are especially vulnerable to unintended pregnancies as they are highly fertile and less reliable in their use of the oral contraceptive pill. Unintended pregnancies have enormous social, psychological and physical consequences as well as significant financial costs to the health system.

One of the key strategies promoted by international public health bodies to reduce the number of unintended pregnancies is for increased uptake of LARCs methods. They are very cost effective largely through preventing unintended pregnancy.

Whilst prescribing a pill is an easy and quick way to deal with a young woman requesting contraception the compliance with all the directions for daily use is often not adhered to because of lifestyle factors and an unintended pregnancy may result. More time discussing LARCs as an alternative may be beneficial.

Then there is the issue of what method of LARCs could be used. There are pros and cons of all these methods and time is needed to go through these and longer consultation time is needed. Delaying whatever method chosen may in itself lead to an unplanned pregnancy.

So there are some barriers in promoting LARCs in the general practice setting:

1. Time to discuss the options
2. Encouraging the patient to come back for further discussion
3. Getting the patient to return for the procedure and checking that the woman is not already pregnant.
4. Whilst a depot injection is easy to give and many GPs are skilled in insertion and removal of Implanons this is not so with insertion of IUDs although more training is now happening through some family planning clinics. Some GPs are already skilled in insertion of IUDs.

IUD use in Australia is very low compared with other countries even though they are the most widely used reversible contraceptives in the world. Data from 2003 showed use by only 1.2% of women using contraceptives in Australia compared with 17% in France and 21% in Sweden. The percentage in Australia may be a bit higher now but still significantly lagging behind many other countries.

There is now good evidence that modern IUD devices present minimal risk of infection and no increased risk of subsequent infertility. There is increasing experience of their use in younger women and nulliparity is not considered a contraindication.

All LARCs can be used in women who suffer migraine with aura and in older women who smoke. Overall LARCs have fewer contraindications than the combined hormonal pill. The levanorgestrel IUD (Mirena) is also very effective for treatment of menorrhagia.

Increasing the usage of LARCs can only happen with changing attitudes from health professionals and the general community. A lot of myths about IUDs still exist and are based on outdated research relating to serious problems with devices that have not been used for more than 30 years.

The current IUD devices have improved a great deal over the last few decades and this trend is likely to continue along with increased acceptance and usage worldwide. In Australia the emphasis needs to be more on the benefits of LARCs education and insertion training for GPs.

(1) Black K, Bateson D, Harvey C. Australian women need increased access to long-acting reversible contraception. MJA, 199 (5), Sept 2013.

Dr Andrew Binns

General Practitioner

Lower Limb Ulceration

by Dr Deepak Williams, Vascular Surgeon

This is the first in a series of articles from North Coast vascular surgeons on advances in the management of peripheral vascular disease. Dr Deepak Williams, a vascular surgeon practising at St Vincent's Hospital Lismore, starts off with an overview of the subject.

Lower limb ulceration affects 1% of adult population, and 3.6 % of people over the age of 65. Leg ulcers are debilitating and can be painful, and greatly reduce patients quality of life. They also have a great impact on the economy as significant resources are spent to treat, prevent or decelerate the progression of disease.

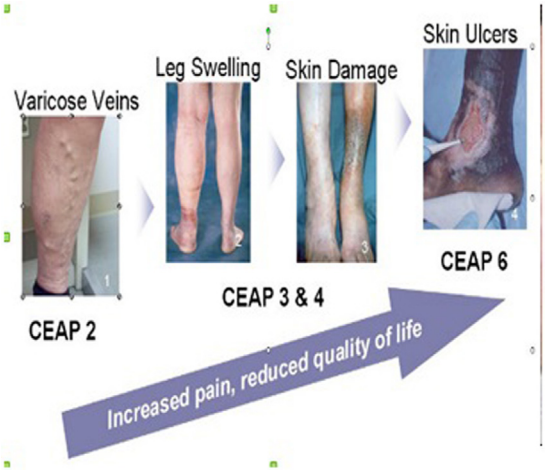
The cause of lower limb ulceration are many as shown in the table below:

- Venous disease
- Arterial disease
- Mixed venous-arterial disease
- Neuropathy
- Trauma
- Obesity or immobility
- Vasculitis
- Malignancy
- Underlying osteomyelitis
- Blood dyscrasias
- Lymphoedema
- Necrobiosis lipoidica diabetecorum
- Pyoderma gangrenosum
- Self inflicted

However 90% of all ulcers are caused by Venous disease, Arterial disease and Neuropathy.

Venous Leg Ulcers

Venous leg ulcers (VLUs) constitute nearly 70% of all lower limb ulcers. The main cause of VLUs is chronic venous insufficiency (CVI). This can be due to reflux in superficial veins or the in the deep veins or both. These ulcers are typically found in the 'gaiter area' above the medial malleolus and are accompanied by tell tale skin changes and pigmentation. VLUs can also be caused by Venous outflow obstruction or combination of both reflux and obstruction. Venous ultrasonography is essential tool in delineating site of reflux or



obstruction.

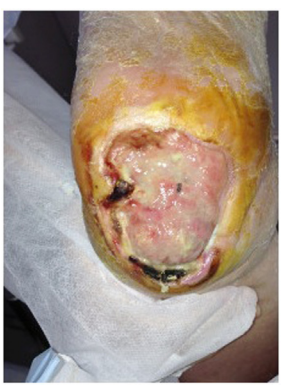
CVI is a serious and progressive disease and severity is classified according to CEAP Classification as shown in the diagram is based on the Clinical classification, Etiology, Anatomy and the underlying Pathology.

There is excellent data now that the best way to treat superficial venous reflux is surgery, whereas deep venous reflux is best treated with compression bandages or stockings in the community.

The recurrence rate of VLUs have been reported to be between 40-69%. The majority of recurrences can be prevented wit Grade II compression stockings, but for severe venous hypertension , and large diameter calves Grade III stockings are required

Arterial Leg Ulcers

Arterial ulcers are caused by arterial insufficiency, usually due to atherosclerosis. Many arterial pathologies can lead to arterial ulcers, but one unifying cause is arterial obstruction. Arterial ulcers constitute 10-30% of all ulcers. (cont p9)



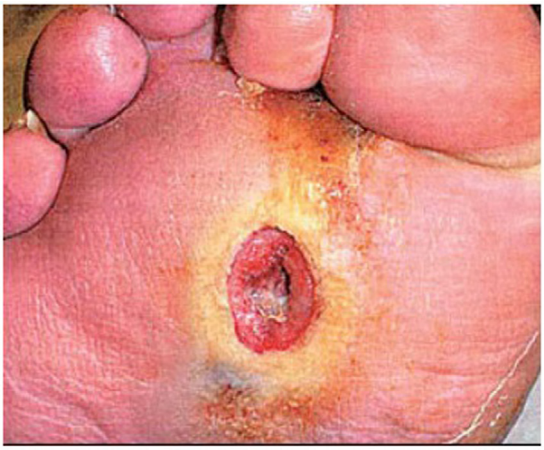
Leg Ulceration - cont from p8

They are typically painful and affect the toes and/or pressure points such as heel, malleoli, and shin. Patients with PAD have heightened endothelial and platelet activation secondary to pro-inflammatory/pro-thrombotic state , among other complex processes.

Some risk factors for peripheral arterial disease (PAD) include smoking, diabetes mellitus, hypertension, elevated LDL, elevated fibrinogen and advanced age.. Thrombotic events due to emboli from heart, aneurysms, plaques, and hypercoagulable states may also be responsible for developing ischaemic ulcers.

Typical investigations include measurement of ankle brachial index, ultrasonography and arteriography. Treatment requires lower limb revascularization, best done by angioplasty and occasionally by bypass surgery

Neuropathic Ulcers



These are the next most common type of leg ulcers, comprising of 15-20% 0f all ulcers. Typically these are patients with diabetes which is poorly controlled and/ or longstanding. Nearly 60-70% of all diabetics have neuropathy, 15-20% have PAD only, and 15-20% have both. The neuropathy involves all three kinds of nerves – motor, sensory and autonomic. The involvement of motor nerves causes atrophy of the muscles of the foot and leg, leading to clawing of toes and prominence of the metatarsal heads. Loss of sensory nerves leads to repeated trauma and loss of autonomic nerves leads to loss of skin turgor

Neuropathy combined with poor healing in diabetics will go on to ulceration and infection which can get out of control very quickly.

Mixed Aetiologies

About 14% of all ulcers have mixed arterio-venous aetiology and rarely about 2% have mixed venous and lymphatic disease

Obesity

With rising obesity in the developed world, there is an increasing incidence of lower limb ulceration in these patients which is often due to undetected venous outflow obstruction.

When to Refer

The general recommendation is that specialist opinion should be sought if an ulcer is not showing signs of healing in 4-8 weeks time. Early intervention not only promotes prompt healing but also reduces recurrence.

The majority of the VLUs can be treated in the primary setting. Specialist opinion should be sought if:

- There is diagnostic uncertainty
- Atypical ulcer characteristics and location
- Suspicion of malignancy
- Treatment of underlying conditions, including diabetes mellitus, rheumatoid arthritis and vasculitis
- PAD indicated by ABPI less than 0.8 or more than 1.2
- Ulcers have not healed within three months
- Recurring Ulcer
- Healed Ulcer with a view to venous surgery
- Antibiotic resistant infected ulcers
- Ulcers with uncontrollable pain
- Patients with traumatic injury with history of venous disease

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On training as a rural doctor

"General practice is both an extremely challenging and rewarding area of medicine. The doctors and staff… were absolutely fantastic" - Dr Caydee Pollock

In 2012/13, South African-born Caydee Pollock undertook a 12-months, integrated, community-based clinical placement on the Northern Rivers facilitated through the University Centre for Rural Health (UCRH) North Coast.

Enrolled in the University of Wollongong's Bachelor of Medicine/Bachelor of Surgery degree program, Caydee – now Dr Pollock – received additional education on rural and remote public health and multidisciplinary teamwork.

Living in Lennox Head with fellow UoW medical undergrad Hannah Walker, Caydee, who had grown up on the Gold Coast, trained in Emergency Medicine, Paediatrics , Obstetrics and Gynaecology , Surgery and General Medicine on hospital based attachments in Lismore and Ballina, and immersed herself in general practice during a year-long placement at Goonellabah Medical Centre in Lismore.

Both Caydee and Hannah graduated with stellar results in December 2013, with Hannah jointly receiving the UoW University Medal, and, like Caydee, being placed on the Dean's Merit List.

While Hannah has chosen to remain in Wollongong, where she is training as an intern, Caydee has returned to the Northern Rivers and is part of the 2014 cohort of interns at The Tweed Hospital.

Dr Caydee Pollock was interviewed by GPSpeak during the first weeks of her hospital internship...

I studied medicine at UOW, where I undertook my undergraduate studies in Biomedical Science. I decided to undertake my internship in a rural area based on my experience as a student.

Smaller rural hospitals provide great learning opportunities and I believe there is greater support from senior clinicians, with a high clinician-to-intern ratio. In addition to this, working in rural setting allows you to develop close ties with the local community, which is an important factor in achieving a good work-life balance.

Finally, working in the Tweed allows me to be closer to my family and friends who provide great social support.

Why this area in particular?

The UOW graduate school of medicine has strong ties with the UCRH and clinicians in the Northern Rivers. Last year I undertook a year-long clinical placement in this region where I spent time in the primary care setting as well as in the hospital.

Over the year I experienced great medicine and developed close ties with the local community.

I had such a positive experience that I decided to return and undertake my internship here. My family also played a big part in my decision to come back to Northern NSW.

What was your impression of the co-ordination by the University Centre for Rural Health?

The team at the UCRH was absolutely fantastic and played an essential role in ensuring my time spent on the North Coast was both enjoyable and highly educational. The facilities were top class and the student support teams were fantastic in ensuring our terms ran smoothly and our needs were met.

(cont p11)

A Rural Doctor - cont from p10

What did you think of general practice after doing a lengthy placement at Goonellabah Medical Centre (GMC)? Are you likely to return to the primary care setting after your internship?

Undertaking the clinical placement at GMC made me realise that general practice is both an extremely challenging and rewarding area of medicine. The doctors and staff at GMC were absolutely fantastic. Dr [Andrew] Binns got me parallel consulting right from the get-go, which at first was a bit daunting but ultimately provided the best learning experience and helped make the transition from medical student to doctor a bit easier.

Prior to commencing my placement at GMC I had never really considered general practice as a potential career path, but having experienced what it has to offer, makes it a very attractive specialty. I also have a great interest in pediatric, critical care and emergency medicine.

Comment by Dr Andrew Binns, Goonellabah Medical Centre:

I sometimes think that there is some reluctance on the part of GPs to offer their services as a GP preceptor for medical students because they don't think it will be a sufficiently stimulating learning experience for them.

Now in our 5th year of having a UoW medical student in our practice at GMC for two days per week of a university year, the experience has been very positive for us and hopefully for our students.

At least we have been able to provide some wisdom in clinical management and it is surprising just how much learning can be gained from parallel consulting both within the consultation and afterwards with further reading and discussion.

We have come to realise that we see so much clinical medicine in general practice, and although we may not be as adept at researching a topic as our students via the internet, we can engage students with lots of experience in clinical and communication skills with our patients.

Our own student training many years ago was highly likely to have been in specialist rather than generalist clinics.

At GMC we have been very impressed with just how well our students have been accepted by our patients, our staff and with GP colleagues, which augurs well for the quality of our next generation of doctors.

On the road to discovering yoga's birthplace

Angela Bettess negotiates the hazards of travelling in India to discover that the age-old discipline of yoga may have much to offer.

As travellers to India well know, coming here is an experience on all levels of the senses and emotions - the smells, the poverty, the people's enthusiasm, their willingness to please, the dangers to one's health - and I am grateful to have been a part of this amazing country, even for a short time.

We began in Mumbai and were greeted by former doctors in our Northern Rivers region, Sejal and Prasanna Mishra. They gave us clear instructions to help us avoid illness, for example bottled water only (including cleaning teeth), no salads or anything that may have been washed in water, cooked food only, be careful with street food as it may have been sitting there for some time, and eat in places which have either been recommended or are popular, judged by a high food turnover.

As well as this key advice, our education in religion and culture in India also began with the Mishras, and germinated the seed that I might try yoga.

The traffic in the major cities and on highways is something that continues to astound me. We practised crossing roads between cars, buses, trucks, tuk tuks and rickshaws. It seems there are no road rules and no actual lanes for traffic. Driving across lanes is acceptable and indicators are not used.

My assessment of indicators related to horn blowing, but not in a sense of road rage but an auditory prompt. One horn blow means I am just letting you know I am here. Two horn blows means I am overtaking you so keep left (or right) depending upon where I appear. Continuous horn blowing means ... get out of the way, I am coming through!

In Delhi, we were travelling in a tuk tuk which overtook an ambulance with flashing lights while being stuck in the usual traffic jams of banks of honking vehicles. We were told that the requirements to survive on the roads in India are a good horn, good brakes and good luck!

Having thought about the two major areas pertinent to our health (that is, being killed or maimed on the road and contracting an infectious disease likely to put you out of action), my mind turned to the health of Indians in general. We had travelled through Rajasthan and had been to many forts and temples, including the amazing carved marble temple of the Jains in Ranakpur.

The majority of Indians are Hindus and so our education began with the three main deities - Brahma the creator,

(cont p 13)

On the road - in India (cont from p12)

Vishnu the maintainer and Shiva the destroyer. The other main religious groups in India are Muslims, Christians and Buddhists. The intimate sharing of health with religion became more and more evident with our travels and reached a pivotal point upon arriving in Varanasi.

Varanasi is well known as being situated on the Ganges River, which has its origins from a glacial ridge in the Himalayas and moves through 2,525 kilometres of India before it empties into the Bay of Bengal at Kolkata (ex-Calcutta). The river is not just a waterway for the Indian people but a spiritual living being, which was sent by Vishnu to Shiva, according to belief. She is "Mother Ganga" and it is believed that bathing in the river will cleanse the body spiritually.

At Varanasi, we visited the ghats, which are steps leading down to the river, viewing them by boat in both the evening and the morning. Bodies are carried to certain places along Mother Ganga to be burned, with the ashes placed by relatives in the waters.

Our travels led us, not downstream with the flow, but upstream to Haridwar and then Rishikesh. The former, like Varanasi, is a high spiritual place for pilgrimage by the Indian people. Mother Ganga passes through both places and we enjoyed immersing ourselves in the ceremonies at the ghats. It was in these places that we visited some ashrams, which are places of education, not only in religious practices, but also in training skills such as incense making, painting, sewing and so on.

We sought out the Beatles' ashram in Rishikesh, only to find that, like the band, it is no longer functioning. Rishikesh is considered to be "the city of yoga" and our interest in its practice and benefits began here with our first yoga and meditation classes.

We realised that these practices were very much a part of life and health in India as evidenced by our conversations and observations in our travels. Yoga and meditation are used for inner spiritual health as well as physical health and strength. Yoga has a long history and there are various types of yoga, with influences from Hinduism, Buddhism and Jainism.

My brief search for evidence of the benefits of yoga in the medical literature found a Cochrane review for the benefits of yoga in the management of chronic back pain. Other areas of interest drew inconclusive results for many diagnoses, including mental health disorders and suggested that further studies in the form of RCTs need to be conducted.

Anecdotally, yoga has been suggested as a good way to alleviate the symptoms of anxiety and depression whilst simultaneously building up the body's physical core strength. I wish to emphasize that my searching is derived from review articles and is not a comprehensive systematic review.

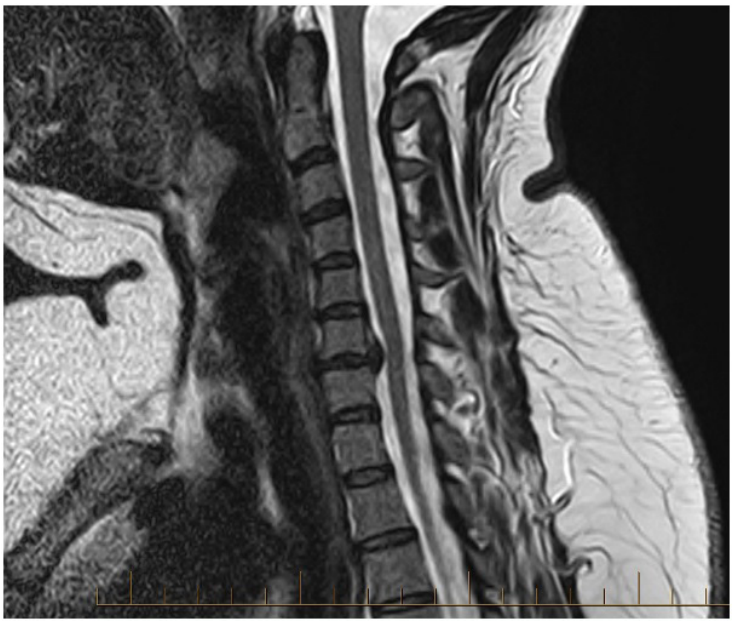
I would welcome any references to research that demonstrates conclusive results in a well constructed study. These could be directed to our yoga-practising editor at editor@nrgpn.net.au

Meanwhile, I will be seeking out a suitable yoga teacher, or preferred style, to continue with the classes that began in Rishikesh.

The New Indications for MRI

by Dr Rohit Singh, NCRG radiologist

With the growth of MRI examinations which can now be referred by GPs for both adults and children, it is timely to present a summary here – not least because Medicare eligibility is tied to the clinical indications. This article intends to summarise the correct clinical indications along with a high level reminder of the contraindications to support GP's and Patients and minimise Medicare compliance issues for everyone involved!



MR cervical spine001.jpg – Cervical Spine MRI showing disc extrusion at C6-7 level mildly indenting the spinal cord.

Paediatric patients - under 16 years

The following Medicare rebates became available to GP's 1 Nov 2012 – with the intention to reduce radiation exposure for this group:

1. MRI Brain
   - Unexplained seizures
   - Unexplained headaches, where significant pathology is suspected
   - Paranasal sinus pathology which has not responded to conservative therapy
2. MRI Spine
   (cervical, thoracic, lumbar or sacral spine)
   - significant trauma
   - unexplained neck or back pain with associated neurological signs
   - unexplained back pain where significant pathology is suspected
3. MRI Knee
   - suspected internal joint derangement
4. MRI Hip
   - suspected septic arthritis
   - suspected slipped capital femoral epiphysis
   - suspected Perthe's disease
5. MRI Elbow
   - fracture or avulsion injury is suspected
6. MRI Wrist
   - scaphoid fracture is suspected

Adults - over 16 years

In addition, commencing November 2013, GPs can now request the following MRI services for patients 16 years and over based on the following clinical indications:

1. MRI Brain
   - unexplained seizure
   - unexplained chronic headache with suspected intracranial pathology
2. MRI Cervical spine
   - suspected cervical radiculopathy
   - suspected cervical spine trauma
3. MRI Knee
   - following acute knee trauma
   - with inability to extend the knee suggesting possibility of acute meniscal tear
   - clinical findings suggesting acute anterior cruciate ligament tear

For the Medicare rebate to be applicable, one of the above clinical indications must be clearly stated in the request form .

(cont p15)

Health care alliance pushes multidisciplinary GP care

In a submission to the Australian Government's review of Medicare Locals the Australian Health Care Reform Alliance (AHCRA) has urged a "multidisciplinary integrated approach to health care, arguing that significant evidence favours this model as an effective way of meeting patients' needs.

Citing the management of diabetes and mental health conditions as "obvious examples" of the benefits of coordinated care, the coalition of some 30 peak health groups hoped Medicare Locals would work alongside GP practices – the majority of which still comprise of one or two practitioners – to evolve the sector into a network of multidisciplinary services.

This would ensure consumers could receive "the right care at the right time from the right practitioner in a team-based manner."

Noting that Medicare Locals had made a strong effort to involve GPs in the new entities, the advocacy group stressed the centrality of primary health care, and noted that improvements could include performance evaluation based on indicators reflecting how the community wants the primary health care system to perform. Key to this would be equity of access and treatment outcomes.

The AHCRA responded to the following criteria of the government's review of Medicare Locals -

- The Role of Medicare Locals and their performance against stated objectives
- Performance of Medicare Locals in administering existing programs, e.g. after hours
- Recognising general practice as the cornerstone of primary care in the functions and governance structures of Medicare Locals
- Ensuring Commonwealth funding supports clinical services, rather than administration
- Assessing processes for determining market failure and service intervention, so existing services are not disrupted or discouraged

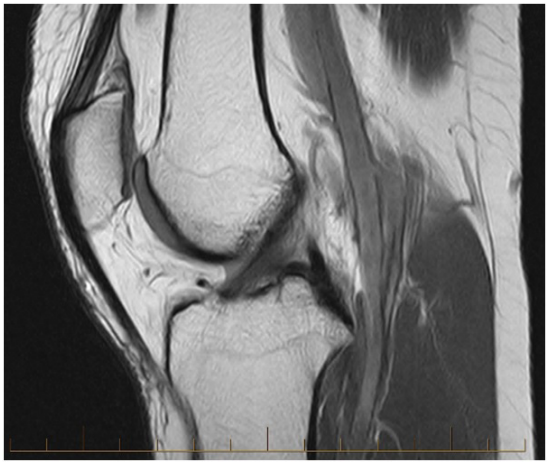
Its submission can be seen at -

the Australian Health Care Reform Alliance

MRI Indications (cont from p 14)

Contraindications - Relative and Absolute

While MRI has major benefits, it is not always suitable for patients where certain (cont p15)contraindications may exist eg, non-MRI compliant prostheses and implants, presence of metallic foreign bodies and/or conductors (e.g. wires, metallic surgical staples, some dermal medication patches and some tattoos). Prior to referral, GPs need to inform us if the patient has known significant renal impairment and provide (or organise) an eGFR – as this



MR knee001.jpg – Knee MRI showing normal anterior cruciate ligament

is required in the event of administrating MRI ContrastMRI Form.

To support GPs, NCRG has developed a specific MRI referral form detailing the above new Medicare-eligible MRI items (see image). This form, in addition to making it easy to select the appropriate examination, still maintains space for the GP's own clinical findings and detailed clinical questions to be presented. This, in turn, helps ensure more clinically relevant radiology reports.

If any GPs are unsure about the suitability of the above, or wish to discuss the best imaging strategy for a particular patient situation, we encourage you to contact our locally based radiologists using the referrer hotlines indicated in the accompanying advert here.

Staying@Home

Figures from the Australian Bureau of Statistics show that life expectancy is now 80 years for males and 84 years for females. Those aged 65 can expect another 19 to 22 years of life. The incidence of co-morbidity rises with age and the cost of aged care, though much debated, will increase significantly in the coming years.

Despite the increasing numbers in residential aged care facilities, most patients prefer to remain at home as long as possible. Since this is also less expensive than residential care, it is the preferred option by all parties. The issue for health authorities is how to maintain these patients at home despite their medical problems and general frailty.

The Department of Veterans Affairs (DVA) is in a unique position in the Australian health care system. It is responsible for all medical costs of Gold Card holders, irrespective of whether these arise in the primary or secondary sector. As such it is interested in programs that improve quality of life and reduce global expenditure.

The DVA Coordinated Veterans' Care Program (CVC Program) commenced on 1 May 2011. The CVC Program:-

- uses a proactive approach to improve the management of participants' chronic diseases and quality of care
- involves a care team of a general practitioner (GP) plus a nurse coordinator who work with the participant (and their carer if applicable) to manage their ongoing care
- provides new payments to GPs for initial and ongoing care

The program has proven popular in the Northern Rivers with 20 practices taking part to date. The program is flexible permitting either community nurses or practice nurses to act as the care co-ordinator. The vast majority of North Coast surgeries use their own practice nurses in this role as it simplifies communication between members of the care team.

The program is primarily directed at those Gold Card Holders at high risk of hospitalisation. Those with CCF, IHD, COPD, pneumonia and diabetes are specifically targeted. Sixty percent of Gold Card holders have at least one of these diseases. However, the best predictor of future hospital admission is past repeated admissions.

The DVA has identified about 600 patients in the Northern Rivers who are at risk and have sent letters to both Veterans and their GPs. So far 260 veterans have been enrolled in the program with over 70% being in the target group. The numbers are higher again on the Tweed. Nationally over 22 thousand Gold Card Holders and 4,700 GPs are participating in the program.

DVA is exploring further ways to maintain these at risk patients in their home. Home telemonitoring has been trialled in a variety of settings around the world for over twenty years. Studies to date have had mixed results but the technology and the community's familiarity with IT have changed markedly, particularly in the last three years.

Following the change in government the In-Home Telemonitoring for Veteran's trial has been extended to areas outside the National Broadband Network footprint. Practices in the Northern Rivers and Tweed Valley are now eligible to participate. The program will use videoconferencing and in-home monitoring devices to check on parameters such as weight, pulse, blood pressure and glucose. Veteran's will need to commence or continue a CVC program. The trial will end in June 2015.

The DVA is conducting information evenings next Monday, 17 February 2014 on the Tweed and Tuesday, 18 February 2014 in the Northern Rivers. GPs, nurses and practice staff from interested practices are all invited to attend.

Uni clinic targets campus mental health

The mental health of students and staff at Southern Cross University's Lismore campus is an increasing priority for the multi-million-dollar Health Clinic where two fulltime GPs will shortly join the ranks of the facility's already broad clinical lineup.

They will provide the first regular GP services on the busy campus, since the closure of the long-running GP clinic in the central plaza area, which also had a strong focus on the psychological well being of students.

According to an in-depth psychological study of Lismore's students and staff, a significant proportion are facing high levels of stress, anxiety and depression.

Currently, there are 4,000 on-campus students and 670 full or part-time academic and administrative staff. All are encouraged to access the clinic's doctors and allied health clinicians, if necessary, as will be the general public when an advertising campaign starts soon.

The study, SCU Student Health & Wellbeing, was conducted last year by Prof Andrew Cashin, Dr Ann Mulder, postdoctoral researcher, and clinical psychologist, Dr Jonathan Munro, who works at the purpose-built health clinic which opened in 2010.

The findings have been a call to action by university authorities, and in turn the clinic itself.

"We are committed to responding to this study," clinic manager Marlene Assim told GPSpeak during our recent visit, adding that strategies to improve personal wellbeing will be a priority during student orientation in February.

At SCU's campuses at Lismore and the Gold Coast – where another GP is set to commence full-time soon – the focus will be on "Brain Busters and Mindfulness Meditation" and 'Improving Psychological Wellbeing with Exercise and Diet".

A range of health checks, including immunisation updates and sexual health advice, will also be offered, while in April a Mental Health Day will offer support on a range of wellbeing issues, including drug and alcohol advice.

Both Men's (in June) and Women's (September) Health Weeks will also prioritise mental health, while October is Mental Health Month, with a focus on helping young people to lead happier lives, with body image and identity, and 'bully busting' being major topics.

RN Leanda Parr (right) and admin officer, Terry Kosack in one of the new GP consulting rooms at the Health Clinic on Southern Cross University's Lismore campus.

On the mental health front alone, there will clearly be plenty of work for the incoming GPs, the first of whom starts at the Lismore clinic in mid-February, with the second due by April.

Both practitioners have been recruited from out of area. They will conduct a full service, privately run practice supported by RN practice nurses and offering bulk-billed care to students, staff and the broader community.

SCU's clinic already has a strong complement of private allied health practitioners, including psychologists and a social worker, physiotherapy, exercise physiology, podiatry, osteopathy, dietician, and, in keeping with the university's long-standing involvement with complementary medicine, naturopathy and massage.

As well as conventional primary care, through GP consultations and referrals on Medicare endorsed CarePlans to other practitioners (HiCaps access is available for the privately insured), the clinic, co-located with SCU's School of Health and Human Sciences, hosts practicum sessions where advanced level students, under senior supervision, undertake patient/client consultations and treatments at a reduced cost.

SCU's Health Clinic is accessed via Rifle Range Road, East Lismore and has ample parking, including parking for people with a disability. Referrals to allied health practitioners can be arranged through (02) 6626 9131.

Nine Ways To Avoid A Tax Audit

Peter Morrow (partner) **Kris Graham (partner)**

The Tax Office annually releases its compliance program to let taxpayers know which areas will be their focus for the year. To provide some perspective, they expect to data match over 640 million transactions to tax returns this year.

Below are nine common ways to ensure you are not subjected to an ATO audit:

1. Have financial performance that is in line with industry standards

As a matter of course the tax office will statistically analyse your tax return. If your statistics are inconsistent with averages for your industry, if may be an indicator of tax issues such as unreported income, transfer pricing and other issues.

2. Pay the correct amount of superannuation for your employees

If your employees complain to the ATO that their employer has not paid them the right amount of superannuation (or not paid it on time), you are more than likely to get a review from the ATO.

3. Minimise variances between tax returns and BAS

Large variances between the information reported in a tax return compared to Business Activity Statements are likely to trigger an ATO review.

4. Lodge your tax returns on time

A good compliance history will improve the ATO's perception of your business. This includes lodging income tax returns, BAS, PAYG Summaries (Group Certificates), fringe benefits tax returns plus the on-time payment of any tax liabilities

5. Don't consistently show operating losses

Losses in 3 years out of the last five are likely to trigger indicative of problems. There may be genuine reasons, but the ATO is likely to want to investigate these.

6. Ensure all transactions are included

The ATO receive data from the Banks, Stamp Duties Office, Land Titles Office, Centrelink, Share Registries and the RTA, and matches this with your tax return. If an enquiry is triggered because of missing data, the audit will generally cover include income tax, Capital Gains Tax, GST and FBT.

7. Profitability fluctuations are a possible indicator.

The ATO will compare your tax returns year-on-year. Big fluctuations in financial position or particular line items in the tax return can trigger an inquiry from the ATO.

8. International transactions

International transactions with tax havens and related parties are a key area of focus for the ATO.

9. Avoid Publicity

Not all publicity is good publicity when it comes to tax audits!! A major transaction or dispute that is reported in the media will undoubtedly be seen by the ATO. Many business owners are selected for an ATO review after the sale of a high value asset is reported in the paper.

Should you require assistance in dealing with a tax audit or review, or would like further information about audit triggers, please contact Peter Morrow or Kris Graham at Thomas Noble & Russell on (02) 6621 8544

Top honour delivered to popular doctor

It's been a long journey from Karkar island, off PNG's north coast, to the town of Casino, on the north coast of NSW, but if there is one thing in common with the diversity of patients treated by Dr Juriaan Beek it is their appreciation for his dedicated service.

This service has been formally acknowledged by the local GP's receiving of the Medal of the Order of Australia in the 2014 Australian Honours Awards, along with being named as Richmond Valley Council's 'Citizen of the Year'.

Netherlands-born Dr Beek has practised locally as a GP, specialising in obstetrics, since 1980, and feels that in this time he has probably "delivered half the town."

Due to a diminished number of birthing mothers, the difficulty of attracting other GPs with obstetrics skills to share the unpredictable hours of the workload, and the consequently limited training opportunities for midwives at Casino Hospital, local birthing services were recently consolidated at Lismore Base Hospital.

Dr Beek remains closely involved with medical education work, including being a Diploma Examiner for the Royal Australian and NZ College of Obstetrics and Gynaecology Board, and has a lecturing role at the University of Sydney's School of Medicine.

Dr Juriaan Beek - recognised with the Medal of the Order of Australia

Dr Beek enrolled in medicine at the age of 28, after graduating in science and working as an industrial chemist and completing a Masters in physics. It was a visit to the Karkar hospital as an overseas volunteer in the 1960s that sparked his desire for a medical career.

NRGPN heartily congratulates Juriaan Beek on his commitment to the health of so many women and babies in the Richmond Valley and beyond.

Health CEO awarded PSM

It was business as usual for Chris Crawford, Chief Executive of Northern NSW LHD, after being awarded the prestigious Public Service Medal.

The long-serving Chief Executive of the Northern NSW Local Health District (and before that, of North Coast Area Health Service), Chris Crawford was awarded the Public Service Medal (PSM) in the Honours List announced on Australia Day 2014.

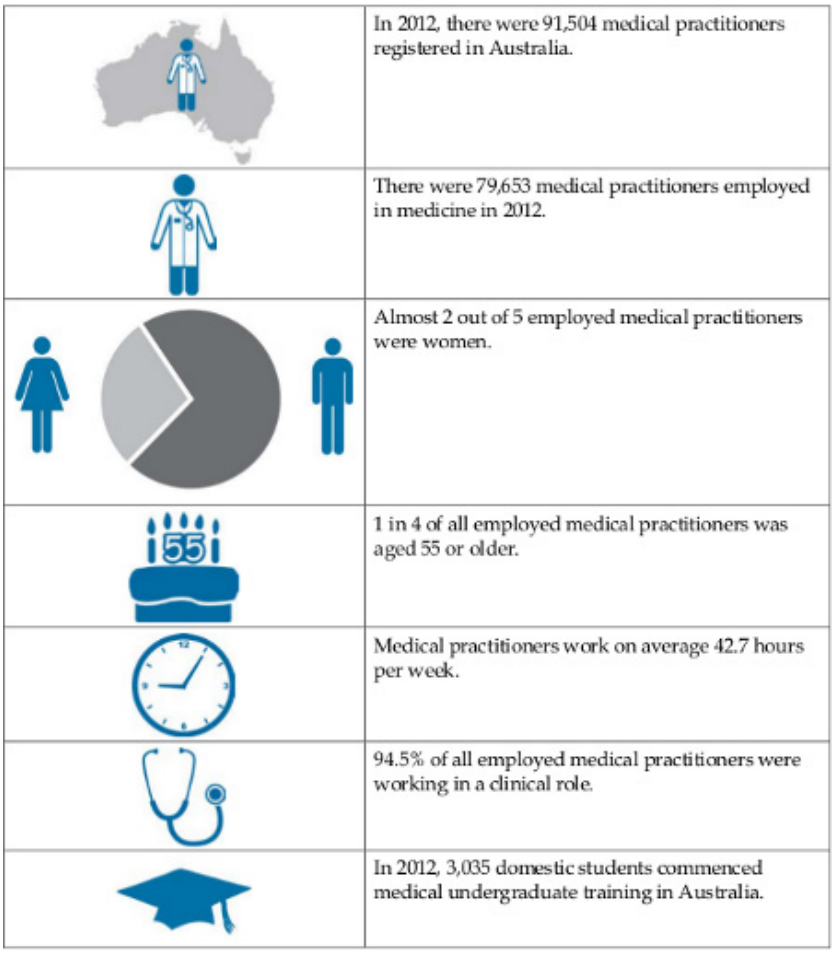
The citation said Mr Crawford had been honoured "For outstanding public service within the public health system, particularly for the North Coast and Northern Rivers communities of New South Wales."

The Northern Rivers General Practice Network wishes to congratulate Mr Crawford for receiving this acknowledgement of his commitment to the public health system and his work in fostering partnerships with a range of local organisations, including NRGPN, the University Centre for Rural Health, Southern Cross University and various aged care providers.

Medical workforce grows unevenly

Australia's medical workforce is continuing to grow, according to the latest study by the Australian Institute of Health and Welfare (AIHW), the national agency set up by the Australian Government to provide regular information and statistics on Australia's health and welfare sectors. It is chaired by a former NSW Health Minister, Dr Andrew Refshauge.

It is not surprising to see that the supply of medical practitioners is generally greater in Major cities than in Remote or Very remote areas. However, the supply of GPs was found to be highest in these remote and very remote areas, at 134 full-time equivalent GPs per 100,000 people.



In the NSW North Coast Medicare Local region there are 538 FWE (Full Time Work Equivalent) GPs for a population of 517,785, i.e. about 104 FWE GPs per 100,000 residents, a ratio close to the state average of about 100 FWEs per 100,000.

Overall, the supply of medical practitioners across all states and territories compared to the population rose by almost 9 per cent from 2008 to 2012, up from 344 full-time equivalent medical practitioners per 100,000 people to 374.

The Medical Workforce 2012 report provides a wide range of detail on the demographic and employment characteristics of medical practitioners registered in Australia in 2012, when there were 91,504 registered medical practitioners. Some 66 per cent of them gained their initial medical qualification in Australia.

Of the employed medical practitioners working as clinicians, some 35 per cent were specialists and the same percentage were GPs.

'Physician', which includes general medicine, cardiology and haematology, was the largest main speciality of practice (5,918). 'Surgery' was the second largest (4,275). Of employed non-clinicians, more than half were researchers or administrators.

Women are increasingly represented in the medical practitioner workforce, with the proportion of female medical practitioners up from 35 per cent to 38 per cent between 2008 and 2012. The average age of medical practitioners remains steady at around 46 years.

The average weekly hours worked by employed medical practitioners remained stable between 2008 and 2012. In 2012, male medical practitioners worked an average of 45 hours per week, while female medical practitioners worked an average of 38 hours per week.

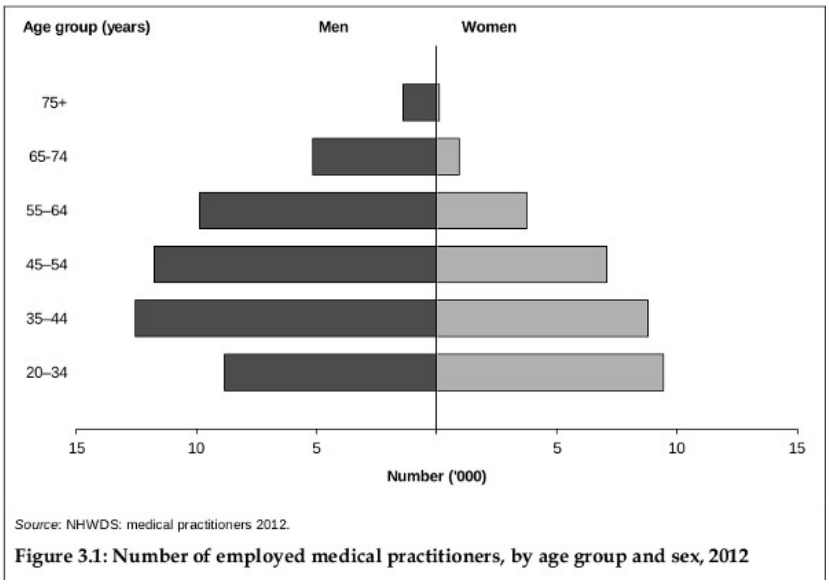
Of all employed clinicians, 46.4 per cent worked in private practice at the time of the survey. Of those working in private practice, about 7 in 10 were in group practices and 3 in 10 in solo practices.

The proportion of women increased from previous years, from 34.9 per cent of employed medical practitioners in 2008 to 37.9 per cent in 2012. Amongst all those in private practice, women were more likely to be working in group practices than (cont p21)

Medical workforce - cont from p20

in solo private practice, making up 20.0 per cent of all solo private practitioners and 39.7 per cent of all those working in group private practice.

'Hospital' was reported as the work setting of the main job



Source: NHWDS: medical practitioners 2012.

Figure 3.1: Number of employed medical practitioners, by age group and sex, 2012

for 43.1 per cent of clinicians. Clinicians working in community health-care services made up only 2.5 per cent of all practitioners employed. Within this small group, 57.8 per cent were working in community mental health service settings, 35.4 per cent in 'other community health-care service' settings and 6.8 per cent in community drug and alcohol service settings.

Educational facilities were the main work setting for 2.1 per cent of all practitioners, but only 0.9 per cent of clinicians reported this as their main work setting. Among all practitioners working in educational facilities, 91.1 per cent were working in tertiary educational facilities.

In 2012, there were 221 medical practitioners employed in Australia who identified as Aboriginal or Torres Strait Islander. This represents 0.3 per cent of all employed medical practitioners who chose to provide their Indigenous status.

In 2012, the average age of employed medical practitioners was 46.0 years, slightly older than the average of 45.7 years in 2008. There were substantially more men in the older age groups, peaking at 86.2 per cent for men in the 75 years and older age group, and slightly more women than men in the 20–34 year age group.

Comment from Dr David Guest, Northern Rivers GP Network Chair:

The figures in the report will not come as a surprise to Northern Rivers GPs.

The change in age, sex and working hours of rural GPs continues a long term trend.

It is pleasing to see that in very remote areas the GP to patient ratio is rising, although specialist numbers in these areas remain relatively low. This reflects both the need for and capacity of multi-skilled GPs in remote Australia and the excellent work the Rural Doctors Association of Australia has done over the past twenty years.

These workforce statistics will be more reliable now that they are being collected, uniformly and nationally by the AIHW and AHPRA (Australian Health Practitioner Regulation Agency). This will give the Department of Health much more information on options for manipulating workforce numbers in the future.

The lag time between setting policy and its realisation is 15 to 20 years. Estimating workforce requirements is a 'black art' and the doctor drought instigated by Dr Michael Wooldridge in the mid-nineties and corrected by Tony Abbot in the mid 2000s (when each was Health Minister in a Liberal / National government) is only now coming to an end.

Claims that there are once again too many GPs are based on the assumption that there will be a 5 per cent annual improvement in productivity. Given the current structure of health care delivery in Australia that would appear to be an optimistic assumption.

It would be wise to proceed with caution.

Order in the House - Delivering quality care across the health system

by Kevin Hogan
MP for Page

I was recently invited to the opening of the $175,000 State Government-funded Northern Brain Injury Rehabilitation Service and Northern NSW Rural Spinal Cord Injury Service perfectly located next to the rehabilitation unit at Ballina Hospital.

We have many outstanding health professions across numerous disciplines here on the North Coast. We also have some fantastic state-of-the-art facilities, such as the Lismore Base Cancer Unit and the soon-to-be upgraded emergency departments at Ballina and Lismore, and hopefully I will be able to announce an upgrade of Casino ED in the near future.

We also have a great network of dedicated and talented GPs, who are usually the first people we turn to when we have an ailment. Then there are the allied health workers who provide on-going care in the home.

Yet I am also acutely aware that as the population ages the demand for health care will increase. We are not alone in having to deal with this demographic shift, it's a national trend.

However, it means we must start thinking about how we can deliver our quality health care services in a more seamless and effective way.

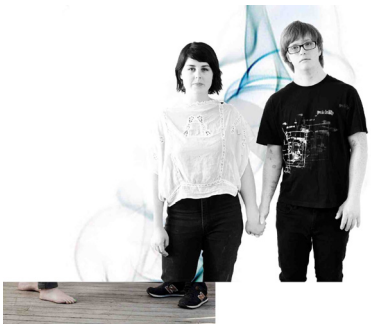
Over the last month, I have contacted local leaders in different health care areas to invite them to a meeting. The idea is to open a dialogue between our various experts so each knows what the other is doing.

The hope is that patient care will improve as experts in field 'A' learn about what is happening in field 'B' and how it may benefit someone in their care. I want to make it easier for people to navigate around the health care maze.

It will also create an informal medical 'brain trust' to allow the cross-pollination of ideas and improve outcomes.

My Radio Heart a true ground breaker

Running in Lismore from 26-29 March, and inspired by the Marvel comic book series X-men and arcade video games, the new theatre work ***My Radio Heart*** was commissioned by NORPA and developed in collaboration with Western Sydney based Urban Theatre Projects (UTP).



The show features the internationally renowned Tralala Blip, a mixed abilities experimental sound ensemble as both the actors and composers.

"***My Radio Heart i***s a ground breaking theatre work that immerses audiences in a breathtaking fantasy world of cinematic audiovisuals powered by an original soundtrack of rock, pop and electronic music," said NORPA's Artistic Director Julian Louis who worked closely with writer and director Rosie Dennis from UTP.

Joining the band is Claudie Frock, known to Northern Rivers locals as her alter ego 'Peggy Popart', while students from Wilson Park School in Lismore have also been involved in the creative process.

Julian Louis is clearly excited by this collaboration with a local community of people living with disability, and promises the show to be an "up close and personal experience like no other

My Radio Heart runs at Lismore City Hall on Wed 26 March, 6:30pm (special performance for NORPA's Bundjalung project, creating a new work engaging with the local community and Bundjalung stories), Thurs 27-Sat 29 March, 7.30pm, plus 11.00am matinee shows Fri 28 & Sat 29 March. Contact NORPA on 1300 066 772 for tickets to the fundraiser.

Bookings at NORPA

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Don't stem the bleeding

While the name of the band may appear to reference the medical profession, and three of its members are practising clinicians, the term 'acid bleed' has nothing to do with doctoring.

In fact the bleeding in question refers to the residual solder flux that is insufficiently rinsed off brass instruments such as saxophones and trumpets before their lacquer is applied.

Over time – I am informed by online bloggers who discuss such things – "this material diffuses from the joint, causing the brass to corrode and this, in turn, causes a failure of lacquer adhesion (why the lacquer flakes off)..."

Fortunately, this occupational hazard has not impacted on the many sounds that founding member Andrew Horowitz can extract from his saxophone, one of the instruments that this talented musician (and fulltime prosecution lawyer) has mastered.

His proficiency with the violin is the result of learning it from the age of 6 to 13, by when he judged it as "not particularly cool" and abandoned it for some years. In such dexterous hands the instrument gives the band an expanded repertoire, which includes Django Reinhardt influences, and enhances their appeal.

Fortunately, too, the band does not bear the moniker of the rock group he played with in Sydney years ago – the Dry Wretches.

Formed in mid-2009 in collaboration with local GP Jimmy Chiu, a handy guitarist [but not a high-end women's shoe designer] who shares Horowitz's love for jazz, gypsy swing and good music generally, the band has developed into an in-demand outfit that plays local venues such as Tatts Hotel and the Lismore Jazz Club, and private functions [for Acid Bleed booking inquiries call 6628 3537].

Present band members are Horowitz and Chiu, cardiologist Adam Blenkhorn (guitar), psychiatrist Harry Freeman (keyboards, sometimes programmed as a vibraphone), police prosecutor Peter Costin-Nielsen (drums), and retired sound engineer Josh Kirk (bass).

David Moore, a GP now living in Sydney, is a former band member, while the current vocalist is Gerry Loong, far more than a 'token female' who rounds out the ensemble with great talent and élan.

Along with gypsy swing and a range of jazz styles, the band plays original tunes, many penned by Dr Chiu, as well as tackling the blues and songs from the contemporary songbook by the likes of Van Morrison, Leonard Cohen and Tom Waits.

While they're not about to give up their day jobs, the 'Acid Bleeders' never fail to receive praise for their performances, and not just because their gigs are, in the main, free of charge to audiences.

Hearing them elevates the spirit and puts a spring in your step, making these dedicated part-time musicians truly deserving of the term 'living local treasures'.

**** The good news is that you don't have to attend a local venue to hear Acid Bleed, as a sampling of their tunes – including a take on Van Morrison's classic Moondance - can be accessed online at Soundcloud.***

Keeping it local with Sullivan Nicolaides Pathology

Although Sullivan Nicolaides Pathology is one of the largest members of the Sonic Healthcare group, we are an independent, Australian owned, publicly listed company.

Sonic practices are medically managed and are thus well placed to appreciate the special needs of doctors and their patients. This means that in the Northern Rivers for over 30 years we have been employing local people made up of specialist Pathologists, Scientists, Courier, Collection and Administration Staff to serve the needs of our community. Most of our testing is performed locally at our Lismore Laboratory meaning that we can ensure a fast turn around and a personalised service to you.

We support our local Doctors and patients by providing 21 collections rooms located between Tenterfield and Ocean Shores with our main procedure room in Lismore which performs bone marrows, skin allergies, paternity testing, arterial blood gases and various other tests. Our collection staff all undergo a Certificate 3 training program with an added emphasis on customer service to ensure all patients needs are met.

Our SNP courier cars cover around 3,000 klms a day from Grafton to Brisbane to ensure specimens reach our labs in the fasting possible timeframe.

We have four pathologists residing in the area with our newest team member being Dr Andrew Bettington. Of course their expertise is underpinned by the fact that our practice is managed by doctors for doctors. Our CEO, Dr Michael Harrison, is a pathologist. All department directors are pathologists, and pathologists are represented at all levels of management.

Finally on a local level, we continue to sponsor our local Doctors with ongoing education events and training and continue to support Southern Cross university science events. As part of your local community we also support various local events including Our Kids, Westpac Rescue Helicopter, local community school awards and underprivileged families at Christmas.

By supporting us you are not only receiving the highest clinical and ethical pathology service but you are keeping our locals that have a vested interest and love of the community employed. Our pathologists and senior management staff encourage doctors to contact them for information, consultation, or advice at any time. Our local Medical Liaison Manager, Vanessa, is available to assist clinicians and their staff with the practicalities of using our services.

Henry V, Circus Oz and more for new NORPA season

The region's leading performing arts company, NORPA has unveiled its 2014 season, with Bell Shakespeare company's production of Henry V, and a new show from Circus Oz among the highlights.

Running at the superbly upgraded Lismore City Hall, the run of shows includes a NORPA original work, My Radio Heart created in collaboration with Western Sydney based Urban Theatre Projects.

"It's a love story for the 21st century, and one of NORPA's most ambitious projects to date," says NORPA Artistic Director Julian Louis.

My Radio Heart immerses audiences in a rich audio-visual fantasy world, featuring local performers Tralala Blip, a mixed abilities experimental sound ensemble, as both actors and composers. Two years in the making, My Radio Heart will premiere at NORPA in March before touring to Sydney.

The NORPA 2014 Season also includes Belvoir and Force Majeure with Food, where the audience will be fed by the actors, while popular children's author Andy Griffiths will meet his fans at performances of 13-Storey Treehouse, the recent Sydney Opera House hit directed by Julian Louis.

The young and young-at-heart can also delight in an Aboriginal interpretation of Snow White and Seven Dwarfs called Wulamanayuwi and the Seven Pamanui.

Another highlight is Lake, a dance work by acclaimed choreographer Lisa Wilson, with the dancers immersed in a stage flooded with water.

More good news is that the high-energy taiko (Japanese-style) drumming ensemble TaikOz will stage a welcome return to our area.

Nights out at Lismore City Hall are civilized affairs, with al fresco dining available, entertainment by local musicians, and a licensed bar operating before all evening shows.

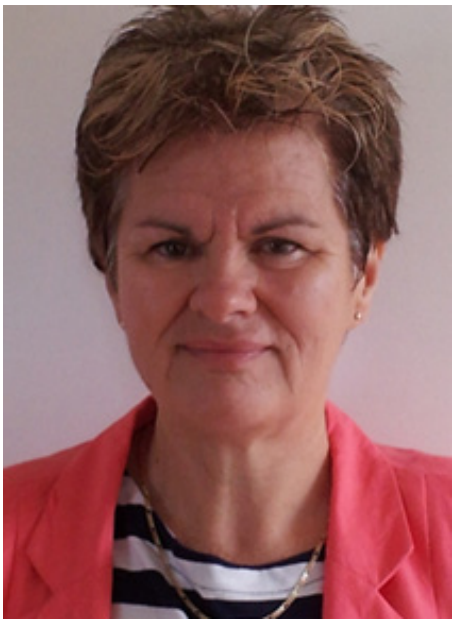
All shows in NORPA's 2014 Season are now on sale. You can purchase tickets to individual shows or save 20% by becoming a NORPA subscriber when you purchase tickets to three shows or more. NORPA subscribers also get access to exclusive Q&A sessions with the actors after evening performances. Popular shows do sell out quickly, so it is advisable to book well in advance.

Visit NORPA for tickets and details.

‘Unhealthy’ nurses may herald future crisis

- SCU Study

A national survey on the health and wellbeing of nurses has shown a high number reporting they feel unhealthy, with stress the major contributor to obesity, hypertension, respiratory disease, musculoskeletal problems, being at risk of developing type 2 diabetes and “not looking after myself properly’”.



The study of more than 6000 nurses - of an estimated 300,000 nurses working in Australia - was conducted by **Kay Ross** (pictured) and Dr Jennie Barr from Southern Cross University’s School of Health and Human Sciences.

It was supported by Australian Government funding under the Chronic Disease Prevention and Service Improvement Fund.

“The results suggest that the overall health of nurses fell between poor and average,” Ms Ross said.

“Only a small number believed their overall health was good or very good.”

The study, ‘Primary health care for nurses: Developing strategies for the Prevention of Chronic Illness in Nurses’, revealed that many “failed their own health-check”, with bullying seen as a workplace issue that contributed to stress and poor health.

Many nurses expressed concern about their workload, the impact of job losses and not being able to give their patients the care they needed.

“Nurses are an ageing workforce, with respondents also concerned about the number of nurses aged over 50 years working part-time and looking at retirement within the next ten years,” Ms Ross added.

Census data from 2005 showed 35 per cent of registered nurses as aged over 50, with the average age of a registered nurse now 45.

The survey found that many nurses had experienced a chronic illness resulting in the need to take time off work in the previous year.

Figures calculated using ‘The Australian Type II Diabetes Risk Assessment Tool’ showed that three per cent of respondents had been diagnosed with Type II diabetes, with a large number at high risk of developing the disease within the next five years.

The research also recorded perceptions about nurses as role models to patients, especially when talking about lifestyle risk factors such as stress, physical activity, smoking, alcohol consumption and nutrition.

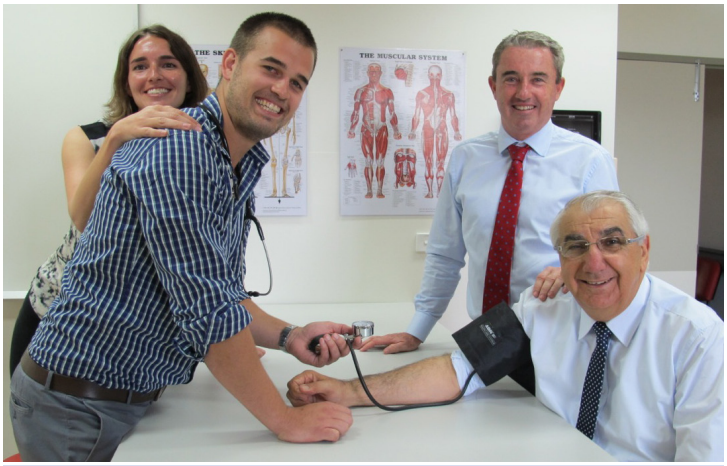
Most respondents felt to effectively discuss lifestyle choices they needed to be healthy as well.

Tomorrow's docs begin North Coast placements

A group of thirteen undergraduate students from The University of Sydney's medical school have begun the 2014 placement component of their training under the aegis of the University Centre for Rural Health (UCRH) North Coast.

UCRH coordinates placements for medical and allied health students from The University of Sydney, University of Wollongong and the University of Western Sydney.

"The students have already completed two years of university study in medicine and are now undertaking supervised practical placements," said Dr Michael Douglas, UCRH's Director of Education.



Emily O'Donnell and Cameron Douglas, two of the 13 incoming students from The University of Sydney's medicine program, got their healing hands on the State MP for Lismore, Thomas George (seated), and the Federal Member for Page, Kevin Hogan. They were on the first day of their year-long North Coast clinical placements. The cohort of 13 students will experience a wide range of clinical settings during their stay.

"These students, and others who will come here throughout the year, choose the Northern Rivers for their placements because of the excellent reputation of our local health facilities and of the many skilled clinicians who so generously impart their knowledge, and allocate their time for the benefit of the next generation of doctors," Dr Douglas added.

"The great diversity of experience offered in a regional setting is also a key attraction.

"Research shows that clinical students who do their placement in a regional/rural area are more likely to settle and work in 'the bush' after they graduate. So we're not just helping them to hone their skills but making an investment in the region's future health care capacity."

The first day of the students' taste of local medicine began with a briefing on the role of the UCRH and an outline of their study program for the coming 10 months. During this time they will have clinical placements at Lismore Base Hospital (LBH), Grafton Base Hospital and smaller district hospitals such as Murwillumbah and Ballina, Aboriginal Medical Services, and GP practices. They also undertook a tour of LBH, a key site for their training.

"Supervised experience of this kind is an essential part of becoming a qualified doctor," Dr Douglas said, "but it's much more than that. We bring to the students a broad understanding of their role as a professional, as an advocate, with an clear understanding of what it means to be a leader in the community. Also, how they have the capacity to better people's lives, both individually and at the community level, as they walk along their vocational journey."

During their placement period the students are exposed to a range of medical procedures and services, such as x ray imaging, cancer care, paediatrics and surgery, through to GP care, Aboriginal health and lifestyle medicine.

"From past feedback, we know that the students who come here benefit greatly from their professional experiences as well as enjoying the wonderful area we live in.

"Many express a wish to come back here to work after they have graduated," Dr Douglas said.

Both Emily O'Donnell, originally from Washington DC, and Cameron Douglas were living in Sydney prior to choosing the Northern Rivers for their clinical placements, as were all but two of the undergraduates. Of those from rural areas, one hails from Kurrajong NSW, the other from rural SA.

Addressing the group at UCRH, Federal MP Kevin Hogan said he hoped they would "fall in love with the area, as we all have, and come back here to practice after qualifying as doctors."

Book Reviews by Robin Osborne

How to Think About Exercise

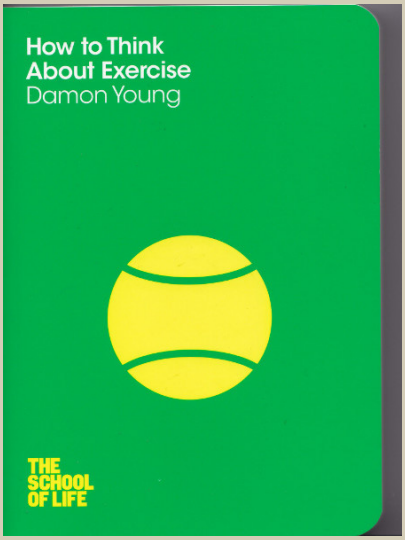
Damon Young

Publisher: the School of Life

Described by the Australian philosopher-author as a non-guide to exercise, this thought provoking and quirky book is published by The School of Life, founded by superstar philosopher and writer, Alain de Botton.

It forms part of a series of 'how to' books about living better, which include How to Age, How to Develop Emotional Health, and How to be Alone. All are by specialist authors, and cost around $12.00.

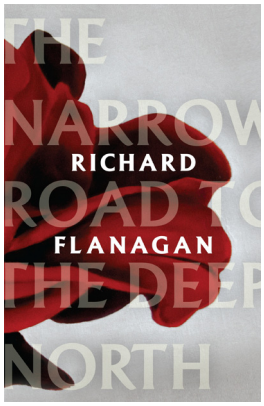
A traipse – and sometimes a jog, or even a dash – through 2,000 years of history, it discusses how some of our greatest thinkers have viewed exercise, and how "our minds can thrive as we sweat and strain – how our muscles swell and flex with the right mindset."



The Narrow Road To The Deep North

Richard Flanagan

Publisher:Vintage/Random house



The memoirs of Australian army doctor Edward 'Weary' Dunlop recorded the challenges of providing medical care to the Allied POWs on the Thai-Burma railway, and the heroism of the troops, not least Dunlop, despite his modesty.

Now, the award-winning Tasmanian writer Richard Flanagan has done it in fictional form, again with a medical officer as its central character, in The Narrow Road to the Deep North.

In August 1943, surgeon Dorrigo Evans and hundreds of long-suffering prisoners are slaving to build the railway through the harsh terrain, wracked by tropical diseases and the unspeakable brutality of their Japanese captors.

The story, whose title is taken from a 17th-century haiku by the Japanese poet Basho, moves backward and forward in time, as Evans muses on his jungle circumstances, his illicit love affair with the wife of an uncle, and his unwillingness to commit to another woman who believed their futures were intertwined.

A born womaniser, as we learn when he returns to Australia and pursues a successful medical career, Evans is the war hero with civilian feet of clay. Almost a god to the men he tended during the dark days of imprisonment, he is revealed as deeply flawed when in command of his own destiny.

Wealthy, feted by colleagues, honoured for his wartime courage, he is now at his happiest when in the warm, secretive embrace of his latest female admirer.

While his internal anguish is deeply disturbing, both for him and the reader, it is the harrowing vignettes of the railway construction – a project made all the worse for being ultimately futile – that most haunts.

The Japanese guards are portrayed as unrelentingly fanatical and sadistic. If the portrayal was not so accurate they might be dismissed as jingoistic stereotypes, but enough has been recorded about the prison camps, and this project in particular, for us to know that we are reading non-fiction.

Of course there is poetic licence – the book is remarkably poetic, as the title suggests – but it relates to the personalities, including Evans himself, not the historical events.

Widely and deservedly praised, this is already one of the 'great Australian novels', and according to many, a dead sitter for this year's Miles Franklin Award.