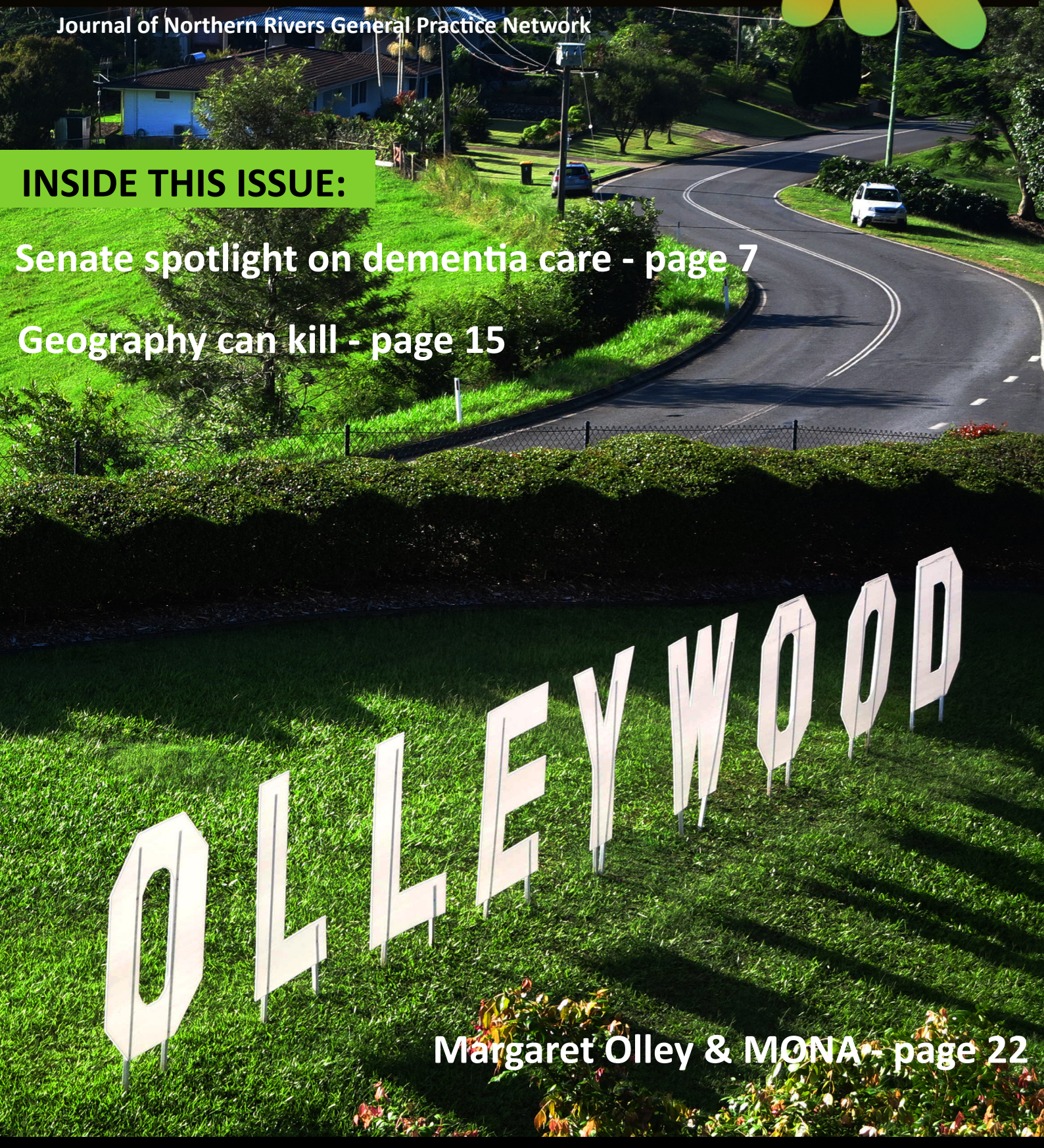
GPSpeak

Journal of Northern Rivers General Practice Network



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April - May 2014

Chair's View

by Dr David Guest

Modern general practice is not confined to the consultation room. Practitioners are constantly striving to improve our medical knowledge and keep abreast of new facilities and techniques available in the local area. When new approaches are enabled by funding changes from Medicare and the Department of Veterans Affairs, we adapt our practices to address the health issues of our patients

We develop our surgeries and our practice teams to enable healthier lives for our patients, particularly those at socioeconomic disadvantage. We liaise with the local health district, the aged care facilities, our pharmacists and allied health colleagues in order to make the system as a whole work more efficiently. We may even try to influence health policy at a local, state and national level.

This edition of GPSpeak touches on all these themes. Dom Simring continues our series on advances in vascular medicine with the first part of an article on the modern management of abdominal aortic aneurysm.

The DVA Telemonitoring trial started in March 2014 on the North Coast and the NNSWLHD/NCML Co-location trial of specialist, hospital based, chronic disease nurses consulting in general practices will begin shortly. The Improvement Foundation through its qiCommunity webinar program is sharing the tips and tricks that makes Care Planning more effective.

As we know so well, a tablet doesn't fix everything. Andrew Binns and Jesse Morgan demonstrate the positive effects of exercise for cancer survivors and those with COPD, CHF and falls risk. If you are over 75 years and don't have an exercise physiologist on your care plan, maybe you should.

Dementia care in aged care facilities is about to change.

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Chair's View... cont from p2

GPs will welcome the Senate's Community Affairs References Committee recommendation for an increase in staff training and numbers. The development and funding of a more modern approach to dementia care is overdue.

The Network strongly supports the work of Graham Truswell and Last Drinks@ 12 in their efforts to minimise alcohol related injuries and sexual assault in the younger members of our community. We too await the survey on alcohol-related presentations at Byron Bay Hospital and the response to this from the "Vibrant Byron" community.

Finally, the Federal MP for Page, Kevin Hogan, is to be congratulated on securing the $3M needed to upgrade Casino Hospital's Emergency Department. While this was a Labor Party promise, secured by the hard work of the previous Member, Janelle Saffin, it could easily have been dropped by the Coalition in the construction of a tough Budget.

Mr Hogan is also to be congratulated for bringing the Federal Health Minister, Peter Dutton, to the Northern Rivers. While the lack of information and community involvement in the early days of the Abbott government stands in marked contrast to that of the previous Rudd government, the Minister listened carefully to those from both the primary and secondary health care sectors. The results of his deliberations should become apparent on the evening of 13 May 2014, Budget day.

We certainly live in interesting times!

David Guest

Contents

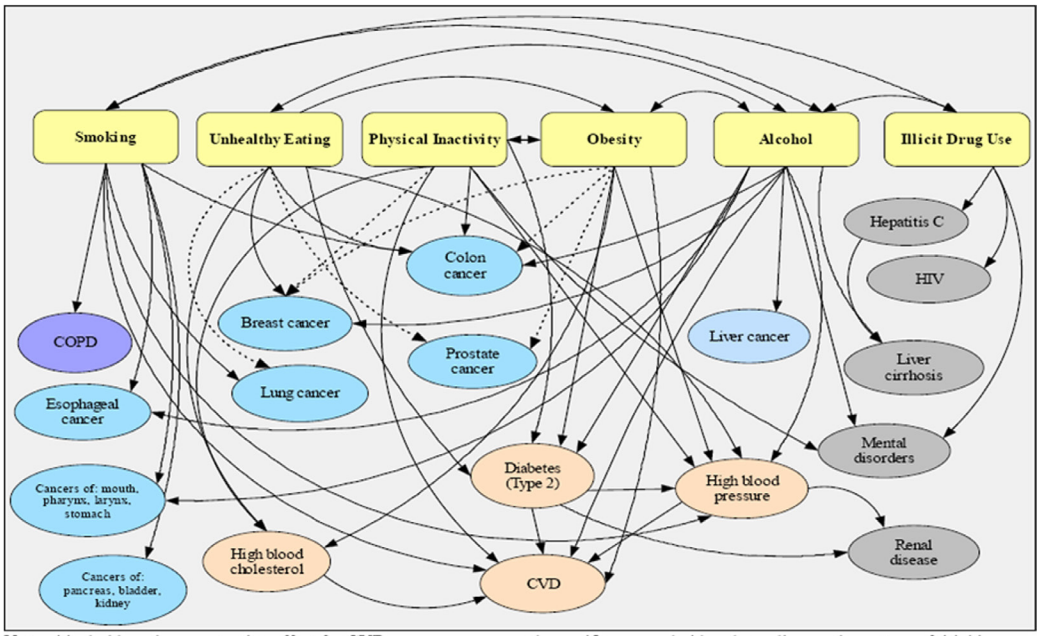
Lifestyle medicine for survivors of cancer

*This article is based on a talk delivered by **Dr Andrew Binns** at the North Coast Cancer Conference in Byron Bay on 29 March 2014. The well attended event featured other talks of interest and relevance to practitioners, and GPSpeak will publish more from the conference in our next edition.*

Cancer survival is broadly defined as being from the time of a cancer diagnosis to the end of the patient's life. A more targeted definition is survival from the end of primary treatment to either a recurrence, or if no recurrence until end of life.

In Australia the five-year survival from all cancers increased from 47 per cent in the period 1982-1987 to 66 per cent in 2006-2010. The cancers that had the largest survival gains were prostate and kidney cancer, and non-Hodgkin lymphoma. (1)

Since the much heralded declaration of the 'war against cancer' in the early 1970s, and the ensuing advances in early detection and molecular understanding of biology of cancer and treatment, there has been a steadily growing number of cancer survivors. (2)



Note: Alcohol has also a protective effect for CVDs among women and men 45 years and older, depending on the pattern of drinking; the link to diabetes also depends on volume and patterns of drinking.

Lifestyle medicine is defined as the application of environmental, behavioural, medical and motivational principles to the management of behaviour-related health problems in a clinical setting. (3) Lifestyle management can reduce the recurrence of primary cancers, improve quality of life and extend the duration of survival. For example, in breast cancer, a 30-40 per cent reduction in the recurrence rate was observed in women who followed weight management and exercised regularly. (4)

After active treatment there is a need to detect recurrence and/or new cancers, the later effects of primary treatment, to prevent future cancers and to treat co-morbidities. As regards the effects of primary treatment the stand-out concerns for patients are fatigue, ongoing fear or recurrence, anxiety, depression and insomnia.

There are also body image concerns, for example after mastectomy. Also sexual dysfunction is commonly seen with men following prostate surgery. Osteoporosis and sarcopenia (muscle loss) are significant risk factors. Pain can be chronic and cardiac and pulmonary complications can occur.

There is a significant overlap between the risk factors for many types of cancer and those for other chronic diseases. Lifestyle choices such as smoking, unhealthy eating, inactivity, obesity, alcohol and illicit substance abuse all have proven links with chronic disease. These complex connections are illustrated in the intertwining diagram shown above.

To be successful, advice on healthier living needs to be practical, achievable and of course, come across as non-judgemental, hard as this may be at times. For instance, healthy eating tips should avoid specific dieting. Far better is to advocate more natural, less processed food that can be found in our farmer's markets, or of course supermarkets, despite the many less healthy temptations.

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Cancer Survivors *(cont from p4)*

Traditional food choices, such as Mediterranean, Asian, Aboriginal or Nordic, are recommended Be mindful of portion sizes. Limit drinks with high sugar and caffeine content, and watch alcohol consumption.

Physical inactivity leads to loss of lean body mass (sarcopenia), increased fat mass, particularly around the waist (central and visceral), but it can also infiltrate muscle (marbling). There may be increased osteopenia and osteoporosis, reduced VO2 max (lower fitness level), and increased insulin resistance, leading to impaired sugar metabolism.

So what sort of exercise is good for cancer survivors? As with everyone the emphasis should be on aerobic exercise and resistance training. If lower limb mobility is impaired, upper body exercise is an alternative as Paralympians have clearly shown us.

ment of appropriate allied health practitioners can make a big difference in patients' quality of life and longevity.

As cancer survivors often have other chronic diseases, a lifestyle medicine approach for their cancer will also be of benefit with helping manage the co-morbidities. Care plans can ensure that the vitally important cancer specialist follow-up is also adhered to. A team approach to encourage a healthy lifestyle, along with appropriate specialist care, will offer the best survival prospects and quality of life outcomes for cancer survivors.

Photo courtesy of Rainbow Dragons Abreast

A question often asked by breast cancer survivors is whether resistance training increases the risk of lymphadoema?

A study (4) has found this not to be the case, and there is the added benefit of increased strength and functioning. Now popular amongst breast cancer survivors is the sport of dragon boat racing, which helps women physically as well as emotionally as they group together in teams.

To address all risk factors GPs are well placed to assist cancer survivors though the Medicare systems for managing people with chronic disease. A targeted care plan and engage-

References:

(1) Cancer Survival and Prevalence in Australia – period estimates. AIHW 2012

(2) Siegel R, Naishadham D, Jemel A. CA Cancer statistics, 2012 Cancer J Clin; 62:10-29

(3) Egger,Binns,Rossner 'Lifestyle Medicine' McGraw Hill (2nd Edition) 2012

(4) Ibrahim EM, Al-Homaidh A. Physical activity and survival after breast cancer diagnosis:meta-analysis of published studies. Med.Oncol. 2011; 753-765

(5) Kathryn Schmitz: JAMA Dec 2010, Weight Lifting for Women at Risk for Breast Cancer Related Lymphedema RCT

Rainbow Dragons Abreast

Contact Juliette Sizer

Mobile 0421 550 335

Breast cancer survivors and their supporters are welcome to join this group, which is part of the Rainbow Region Dragon Boat Club.

Glasses Still Half Full

Byron Bay's Last drinks @ 12 group, which includes local GP Graham Truswell (GPSpeak Feb-March 2014), is continuing its campaign for appropriate controls to reduce excessive alcohol consumption, and as a result, alcohol related assaults and accidents.

Representatives of the group are attending meetings of local stakeholders in a process known as 'Vibrant Byron'. According to Dr Truswell, the purpose is to get a more unified approach to the after-hours problems in Byron Bay.

If the endeavour did not seem to be delivering, the next step could be to hold a community poll seeking the views of businesses and residents about whether Byron Bay does have an alcohol violence problem, and whether late-night licensed venues should shut earlier in order to address such a problem.

"We would expect the results to confirm what local people appear to believe, and be concerned about, which would give further legitimacy to the campaign," Dr Truswell said.

Firm statistics on the alcohol-trauma linkage will emerge soon when a medical student doing a research project on data collected on alcohol-related presentations at Byron Bay Hospital will present the findings to the hospital's medical staff council.

Should the results indicate a clear connection between alcohol usage and personal violence or accidents, especially regarding younger people, clinicians may decide to voice their concerns publicly. This would add further weight to the push for reducing alcohol availability.

Byron Bay has the third highest rate of alcohol-related, non-domestic assault of the 154 local government areas in NSW. Some 84 per cent of these assaults are related to the five licensed venues that remain open until 3.00 am.

Except for a reduction in takeaway bottle shop hours, the State Government's recently announced alcohol restriction laws do not apply significantly in Byron Bay.

Senate Committee urges re-think of dementia care

A new report by the Australian Senate's influential Community Affairs References Committee has made sweeping recommendations aimed at improving the wellbeing of dementia patients in residential care facilities.

The report, 'Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD)', took more than a year to prepare. It drew on submissions from clinicians, service providers, advocacy groups and other interested parties, including the Royal Australian College of General Practitioners.

In addition, the Senators held five days of public hearings. The report can be downloaded at

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries

A major finding was that, "The evidence provided by the Department of Health and Ageing seems to confirm that there is significant overuse of psychotic medication in aged care to control BPSD. This overuse must not be allowed to continue."

Several providers who managed BPSD without reliance on chemical or physical restraints highlighted what can be achieved with the current resources available.

The Committee found that the aged care professions did know how to reduce the impacts of dementia and BPSD without resorting to restraints unnecessarily. Key factors in this regard were adequate staff training, education, appropriate facilities, adequate staff numbers, partnerships with carers, and a person-centred focus.

"The use of medication is a symptom of the aged care system not placing enough emphasis on staff training and providing a person-centred focus that engages

the patient in meaningful activities," the report noted.

"Reliance on restraints to manage dementia and BPSD is not an acceptable model of care, especially as more and more Australians are diagnosed with dementia.

"It is necessary to make the necessary investments in training and facilities to ensure that the rights of people with dementia are respected and they are free from unnecessary restraints."

It expressed the hope that recent Commonwealth changes to the aged care system such as the Living Longer, Living Better reforms and the Dementia and Cognition Supplement, would improve the quality of life for people living with dementia.

However, if the ratio of dementia patients on antipsychotics did not decrease, there would be a need for further government involvement.

Among the report's recommendations were that –

- The Commonwealth create a new Medicare item number that encourages General Practitioners, registered psychologists or other relevant accredited professionals, to undertake longer consultations with a patient and at least one family member or carer where the patient has presented with indications of dementia.
- The Commonwealth encourage relevant professional organisations, such as the Royal Australian College of General Practitioners, to ensure that patients diagnosed with dementia and their carers are informed by health professionals of the dementia supports available and how to access them.
- The Commonwealth facilitate and potentially fund the establishment of dementia-specific respite facilities, including in regional and remote areas.
- The Commonwealth, in consul-

cont on p8

Dementia Care Re-Think (cont from p7)

tation with industry, develop guidelines regarding dementia-specific respite facilities that can effectively manage BPSD.

- The Commonwealth explore options for improving the provision of respite in rural and remote areas.
- The accreditation standards for Residential Aged Care Facilities include requirements for dementia-friendly design principles.
- The accreditation standards for Residential Aged Care Facilities reflect a better balance between clinical and quality-of-life outcomes.
- A phased program of accredited training in dementia and the management of Behavioural and Psychological Symptoms of Dementia (BPSD) be required for all employees of Residential Aged Care Facilities.
- The Commonwealth take a proactive stance in highlighting the importance of staff training in dementia care, and develop linkages between care and education providers.
- The use of antipsychotic medication should be reviewed by the prescribing doctor after the first three months to assess the ongoing need.
- Residential aged care facilities, as part of their existing Aged Care Standards and Accreditation Agency annual audit process, report:

o circumstances where an individual has been prescribed antipsychotic medication for more than six months, together with the reasons for and any steps taken to minimise that use; and

o general usage patterns of antipsychotic medications in each facility.

- The Commonwealth develop, in consultation with dementia advocates and service providers, guidelines for the recording and reporting on the use of all forms of restraints in residential facilities.
- The Commonwealth undertake an information program for doctors and residential aged care facilities regarding the guidelines Responding to Issues of Restraint in Aged Care in Residential Care.

Substantial work in regard to the last recommendation is already being done by the Reducing the Use of Sedative Medication in Aged Care Facilities (RedUSe) program, funded by the Australian Department of Social Services and managed by the University of Tasmania (UTAS).

The program partners UTAS, NPS MedicineWise, the Pharmaceutical Society of Australia and BUPA care services. The aim is to engage with GPs, Nurses and Pharmacists in order to foster the best-practice use of sedative medicines, particularly antipsychotics and benzodiazepines, by older people living in the nation's residential aged care facilities (RACF).

NPS MedicineWise's Clinical Service Specialists are now contacting relevant medical practices in several states, with practices in NSW on the agenda for later this year.

"We are confident that the RedUSe program will contribute significantly to the best-practice use of antipsychotics and benzodiazepines by RACF residents," said Dr Juanita Westbury, the RedUSe Project Lead.

"One key strategy is an individual Sedative Review Plan for residents taking antipsychotics and/or benzodiazepines for extended periods. The plan is generated by both the Pharmacist attending the RACF and nursing staff best placed to share their experience of the resident's behaviour and medical history."

Sample plans, along with a copy of the RACF RedUSe guidelines, based on approved national and international practice, will be circulated to GP practices in the coming months.

References

1. Living Longer, Living Better reforms
2. Dementia and Cognition Supplement
3. Falls Prevention for Residential Aged Care Facilities
4. RedUSe: Reducing Use of Sedatives

Strategic investment advice pays off

Therese Pearce

Many medical professionals look to include residential property in their investment portfolio.

Therese Pearce, Medfin Finance's Port Macquarie relationship manager, helps medical professionals manage their business and personal finances and can also help structure residential home loans to suit their unique needs.

Therese believes that while each investor requires their own individual strategy, property investment does not have to be complicated. Here, she shares her top tips for investing in property.

Choose a property tenants will find attractive

Look for property which suits the majority of tenants in your area to ensure your investment is always attractive to local renters. For example, in a region popular with young families, you may want to focus on a home with a backyard as opposed to a one bedroom apartment.

Talk to your financial advisers regularly

This is vital to ensure you have the correct structure in place for your investment and know what fees and charges you are outlaying. A good adviser will understand your financial goals and partner with you to help you meet them.

Look for growth opportunities

Properties which are close to the CBD, leisure facilities, schools, public transport and beaches are often more likely to gain value over time. However, it's really important that you understand the local conditions.

Take a long term view

Taking a long term view to your investment is critical. Selling a property incurs sales costs and taxes, so if you can afford to buy and hold on to your asset for longer, the greater potential rewards you can reap.

Create instant equity through simple renovations

Making simple but high impact renovations can be a good way to maximise the value of your investment property. A good rule of thumb is to aim to get back at least $1.00- $2.00 in value for every dollar you spend on renovations.

About Medfin:

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Before making any financial decisions you should make sure you receive appropriate financial, legal and tax advice.

In Home Exercise for the Older Adult

Jesse Morgan from Embrace Exercise Physiology explains the many benefits of exercise for older people, and why the home setting is easier for some to access.

Australia has an ageing population and the older adult population is the least active of all age groups. Unfortunately, older adults are also the age group with the biggest burden of disease. It would seem that Australia's older adult population is missing out on many of the benefits of staying active.

Exercise has been shown to be effective in preventing and managing a number of conditions common in older adults including diabetes, chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD) and disability as a result of a fall.

In Australia the prevalence of type 2 diabetes is estimated to be 7.4 per cent of the population, with a further 0.7-0.8 per cent of Australians being diagnosed with the condition every year.

Correctly prescribed exercise can be an effective tool for managing diabetes via a number of mechanisms. Acutely, exercise increases blood glucose uptake as glucose becomes the preferred fuel by the muscles during exercise.

In addition to this, muscle contractions increase GLUT4 translocation to the cell membrane, and increase the activity of glycogen synthase leading to increased glucose uptake for up to 24-72 hours post exercise. In the long term, regular exercise can also manage diabetes by causing an energy deficit leading to weight loss and the reduction of harmful metabolic visceral fat.

The prevalence of CHF in the Australian population is approximately 2.5 per cent of people aged 55–64 years, and 8.2 per cent of those aged 75 years and over.

Reduced aerobic capacity and exercise tolerance is characteristic of this population. CHF also has a negative impact on skeletal muscle structure and function, leading to reduced ability to carry out activities of daily living (ADLs).

However, exercise has been shown to improve VO2 peak (a measure of aerobic capacity), as well as muscle mass and strength, to significantly improve the quality of life in individuals with CHF.

It is estimated that in Australia approximately 14 per cent of the population over the age of 40 have COPD. Exercise has been shown to lower perceived dyspnoea, increase capacity to carry out ADLs and improve general quality of life in those with COPD. In addition to this, individuals with COPD frequently suffer from skeletal muscle dysfunction including atrophy, reduced strength, higher lactate levels, reduced capillarisation and oxidative capacity. Exercise plays an important role in correcting these factors.

Falls affect a large number of older adult Australians each year, with approximately 1 in 3 community-dwelling adults over 65 years falling one or more times per year.

Muscle strength and power, reaction

cont on p 12

DVA In-Home Telemonitoring for Veterans' Trial

The Department of Veterans' Affairs (DVA) In-Home Telemonitoring for Veterans Trial that started late last year in Armidale and Toowoomba has been extended to the NSW North Coast. The trial aims to determine if telemonitoring is a safe, effective and efficient complement to face-to-face GP consultations, and will contribute to providing better care for DVA Gold Card holders with high risk for admission. Veterans with chronic obstructive pulmonary disease, congestive heart failure, coronary artery heart disease or diabetes will have access to videoconferencing and remote monitoring of their vital signs by their usual surgery's chronic disease nurse.

The trial, which will run until June 2015 extends the Department's existing Coordinated Veterans' Care (CVC) Program. This program has proven very popular on the North Coast and provides funding to support coordinated care for eligible at risk DVA patients. Both projects hope to catch a deterioration in a patient's condition early so that emergency and possibly prolonged hospital admissions can be avoided.

In mid February the project team from DVA and Tunstall Healthcare (the supplier of the remote telemonitoring equipment for the project) did a whirlwind tour of the North Coast visiting over 30 practices from Tweed to Coffs Harbour. The project hopes to recruit 300 at risk patients for the trial and will match them against a control group to determine the effectiveness of early intervention.

Wayne Delahoy from DVA explained the key features of the CVC Program for GPs and practice nurses. Those practices interested in participating in the trial can get a list from DVA of patients who may be suitable for the telemonitoring trial. Once practices have submitted their application to participate in the trial to DVA, and their patient list has been approved, they can start telemonitoring. This will involve creating or updating the veteran's CVC care plan. It is important that veterans and their families understand that their active participation is key to the success of the trial.

Patient Treatment Reports available from DVA will assist in monitoring patient progress. These can be obtained on request but are also available electronically via Health Professional Online Services (HPOS).

The trial will also encourage sharing of data through the Personally Controlled Electronic Health Record, although this is not an essential part of the program.

Most nurses and GPs are interested in the capabilities provided by the new technology. Tracey Noble from DVA introduced the Tunstall Healthcare project managers, Lisa Capamagian and Ruth Skinner-Smith. Ruth explained that the telemonitoring equipment consisted of a tablet that was locked to the Tunstall monitoring system and enabled with video conferencing capabilities, a health interview that the patient runs each day, as well as the collection of vital sign data from paired Bluetooth peripheral devices.

Connection to the Internet for patients in our area will be via the NBN, ADSL, or a 3G or 4G dongle, whichever is the most appropriate. DVA covers all costs associated with installing the equipment in the patient's home, including the Internet connection. Despite the sophistication of the system Lisa reported that over 95% of 80 year olds can manage the system.

The peripherals that can connect to the system include a blood glucose monitor, lead 2 ECG, pulse oximeter, spirometer, syphmomanometer, scales and thermometer. The equipment provided on loan to an individual veteran is tailored to their needs and CVC care plan.

cont on p 12

In Home (cont from p10)

time and balance can all be addressed with appropriate exercise thereby reducing the risk of falling by up to 34 per cent.

There is no doubt that exercise is good for health and the management of chronic disease in older adults, however the challenge is getting them to do it regularly.

This is where the exercise physiologist plays an important role in instructing, supporting and encouraging older adults to take up and maintain appropriate forms of exercise.

Embrace Exercise Physiology understands that it can sometimes be difficult for older adults to get 'out and about'.

We also understand that many older adults feel uncomfortable and awkward in gym settings. That is why we offer in-home exercise rehabilitation, so that older adults can enjoy the benefits of exercise in a comfortable and familiar environment.

Contact Embrace 0431 320 094

Email: info@embraceep.com

Fax: 0266 78 0444

DVA Trial (cont from p11)

The large volumes of data collected by the monitoring system and sent to the Tunstall database is presented to the GP and practice nurse through a user friendly dashboard, icp triage manager. Events are listed in decreasing order of importance so that important results are highlighted. The telemonitoring system does not replace emergency care and this is emphasised to veterans and their carers.

The ICP Triage Manager software will warn if a patient has missed taking their readings, and the practice can follow this up with the patient. Tunstall Healthcare will provide initial co-monitoring support to practices, and technical support to the practice and patient for the duration of the trial. So, all the practice needs to worry about is monitoring the readings via the web based portal and following up where required.

The ICP Triage Manager can also display collected data in graph format and any information can be copied into the practice's own electronic medical record. A video conference can be scheduled with the patient and practice staff and other family members can join from their own home or work with a webcam enabled computer.

Tunstall Healthcare undertakes installation of the equipment and training of practice staff, veterans and their carers.

Practices interested in participating in the telemonitoring trial but that did not make it to any of the recent demonstrations should contact their NCML Practice Assistant Liaison officer.

A web portal to support the program is being developed by the DVA and should come on line within the next few weeks. The NCML has also setup a Telemonitoring network for local practices.

It's the New Triennium - thoughts on QI&CPD pts

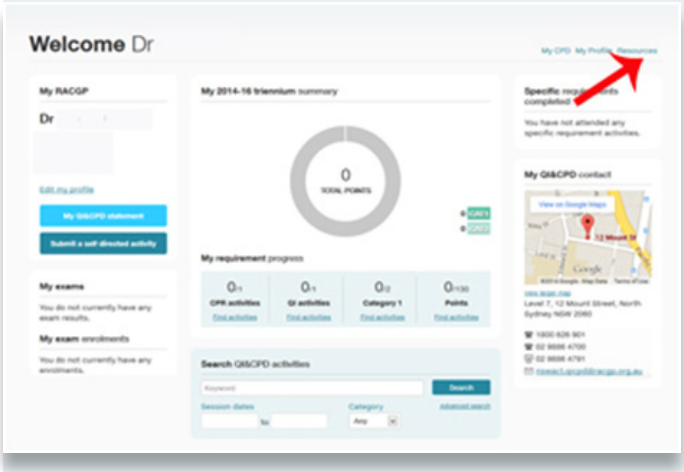
The new triennium for QI&CPD points for 2014-2016 has begun. Now is a good time to consider Small Group Learning (SGL) to gain points in Category 1. The requirement for the RACGP requires two instances of Category 1 points for the triennium which are worth 40 points each.

Experience at Goonellabah Medical Centre

At GMC, there has been a SGL group running for the last 6 years. This group is a general practice based learning group and the ideals of the group are to provide a basis for general practitioners, general practice registrars and medical students to share knowledge and to provide peer support in a safe environment. The group is called GEM (Goonellabah Education Meetings) and is also a metaphor for the "gems" of knowledge which are imparted. The group run two cycles each triennium which , not only provides the participants with 80 Category 1 points, but also allows for reflection about topics and the aims of the group at the end of each cycle. It is not only practitioners from GMC who attend but others from Lismore. The meetings are always robust and dynamic as a result of the enthusiasm from this style of medical learning.

Accessing information about SGL

Login to the RACGP and go to My CPD page and look for resources link top right.

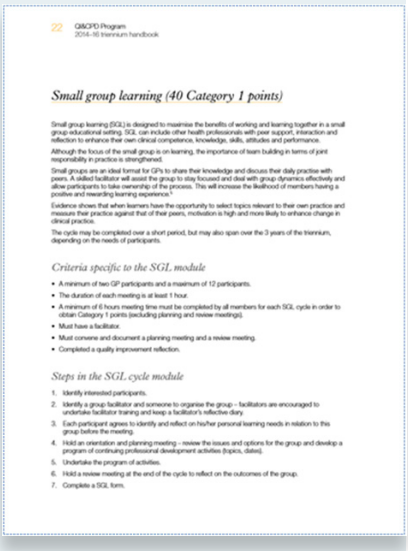


The QI&CPD Program Handbook is available for download in pdf format here.

In the Handbook (on the page numbered 22), there is information about the requirements. A group can choose to have a focus, for example, Womens' Health. The GEM group has chosen to follow a general practice approach and the topics discussed are quite varied. Case studies are popular and practical. Case studies may provide examples which are more broad, such as hypertension, but can be very specific, such as Conn's syndrome. An evidence-based approach to discussion topics is important to the group but the networking of ideas and suggestions provides lots of discussion.

Criteria Specific to the SGL module (taken directly from the Handbook)

- a minimum of 2 GP participants and a maximum of 12 participants
- the duration of each meeting is at least one hour
- a minimum of 6 hours meeting time must be completed by all members for each SGL cycle in order to obtain Category 1 points (excluding planning and review meetings)
- must have a facilitator
- must convene and document a planning meeting and a review meeting
- completed a quality improvement reflection


22 QI&CPD Program 2014-16 triennium handbook

Small group learning (40 Category 1 points)

Small group learning (SGL) is designed to maximise the benefits of working and learning together in a small group educational setting. SGL can include other health professionals with peer support, interaction and reflection to enhance their own clinical competence, knowledge, skills, attitudes and performance.

Although the focus of the small group is on learning, the importance of team building in terms of joint responsibility in practice is strengthened.

Small groups are an ideal format for GPs to share their knowledge and discuss their daily practice with peers. A skilled facilitator will assist the group to stay focused and deal with group dynamics effectively and allow participants to take ownership of the process. This will increase the likelihood of members having a positive and rewarding learning experience.[1]

Evidence shows that when learners have the opportunity to select topics relevant to their own practice and measure their practice against that of their peers, motivation is high and more likely to enhance change in clinical practice.

The cycle may be completed over a short period, but may also span over the 3 years of the triennium, depending on the needs of participants.

Criteria specific to the SGL module

- A minimum of two GP participants and a maximum of 12 participants.
- The duration of each meeting is at least 1 hour.
- A minimum of 6 hours meeting time must be completed by all members for each SGL cycle in order to obtain Category 1 points (excluding planning and review meetings).
- Must have a facilitator.
- Must convene and document a planning meeting and a review meeting.
- Completed a quality improvement reflection.

Steps in the SGL cycle module

1. Identify interested participants.
2. Identify a group facilitator and someone to organise the group – facilitators are encouraged to undertake facilitator training and keep a facilitator's reflective diary.
3. Each participant agrees to identify and reflect on his/her personal learning needs in relation to this group before the meeting.
4. Hold an orientation and planning meeting – review the issues and options for the group and develop a program of continuing professional development activities (topics, dates).
5. Undertake the program of activities.
6. Hold a review meeting at the end of the cycle to reflect on the outcomes of the group.
7. Complete a SGL form.

After establishing your group, appoint a facilitator who needs to keep a reflective diary about the meetings. When all members have reached their minimum of 6 hours of meetings (excluding the planning and review meetings), documentation needs to be sent to the RACGP QI&CPD section in order for points to be allocated. The GEM group try to finish the second cycle in about September/October of the last year of the triennium in order for the points to arrive in each member's personal CPD summary in a timely fashion.

Login link to RACGP QI&CPD Resources

Ref: QI&CPD Program 2014-2016 Triennium Handbook

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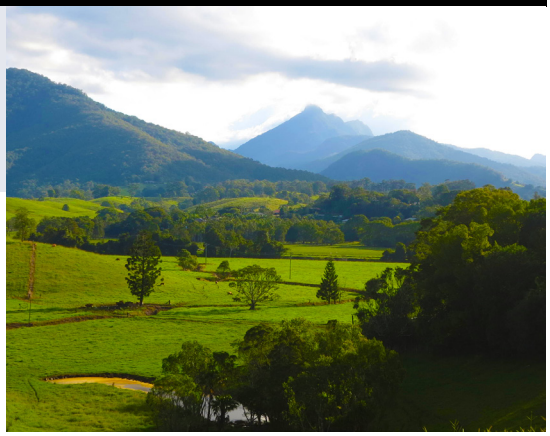
HIRE WITH AN OPTION TO BUY

Unravelling why geography is Australia's biggest silent killer



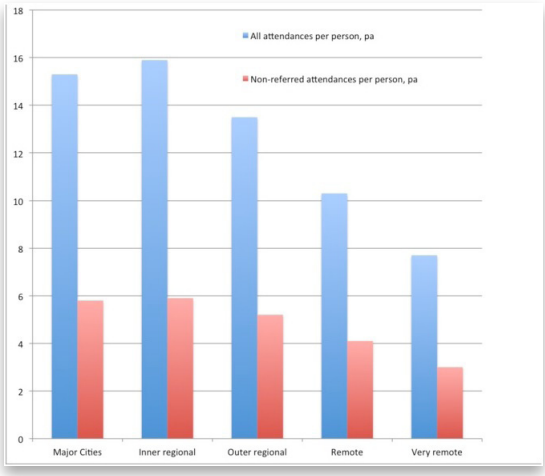
Many people think the poorer health and lower life expectancy of people living in rural or remote Australia are attributable to the under-supply of health services in those areas. But this is only one contributing factor.

Far more important is the distribution of health risk factors and how they interact with the nature of rural and remote places, which results in people dying younger. Data from the National Health Performance Authority shows life expectancy at birth ranges from 83.6 years in metro areas to 81.5 in regional hubs and 78.2 in rural places.

The picture is even grimmer when we look at avoidable deaths. From a population of 100,000, there are 115 avoidable deaths in metro areas compared to 171 in regional hubs and 244 in rural places. Clearly, there's more than one factor at play here.

Compared with those living in major cities, the people of rural and remote Australia have fewer years of completed education and lower incomes. And a greater proportion of them have a disability, smoke, and drink to risky degrees. They also have poorer access to the internet and mobile phones.

And then there's access to health professionals, including doctors, which is notoriously poor in rural areas. Compared with the rate at which city people access Medicare, people in rural and remote areas are at a massive disadvantage – there's a so-called "Medicare deficit" of around $1 billion a year.

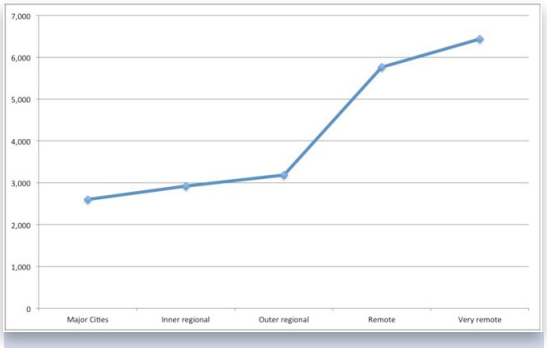


A graph showing Medicare attendance by location. Attendances derived by NRHA using Medicare attendance data and ABS 2012 population data. The rest of the figures are directly from Medistats. Medistats

In 2012-13, for instance, there were 5.8 GP services per head funded by Medicare, compared to 5.9 in inner regional areas, 5.2 in outer regional areas, 4.1 in remote areas and 3 in very remote areas. In country areas, there's also less access to private hospitals, even for those who are privately insured.

And apart from these well-known deficiencies in access to health services, people in rural and remote areas also have less access to health-promoting infrastructure, such as targeted smoking cessation activities, organised physical activities and the information contained in health promotion campaigns.

All in all, there's a slanting line across key health measures such as potentially avoidable death, potentially avoidable hospitalisation and life expectancy from major cities through to very remote areas. Cancer survival rates show the same pattern.



Potentially preventable hospitalisations by location (per 100,000 pop. 2010-11) COAG Reform Council

Social factors that impact health, such as income, completed years of education, disability, smoking and risky drinking, show the same gradient. All of these result in a higher incidence among the people of rural remote areas of various disadvantages relating to work, income, education and children (think of the proportion of families with young children in poverty).

cont on p 16

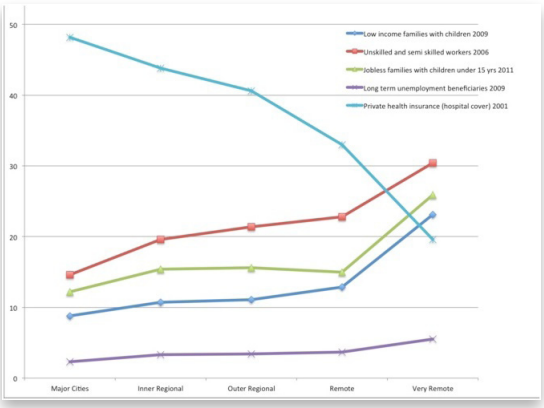
Worse Health By "rurality" *(cont from p15)*

If we are to address these disadvantages, we need to unpick the relationship between socioeconomic status and geography. From an equity standpoint, the important issues are why levels of employment are low, why in a particular place there are few professionals and many labourers, why internet access is low, and why are there fewer people with education above year 11 – and what can be done about these things.

It seems safe to assume that the causes of health deficits include "rurality" – a combination of remoteness and town size because it's obvious that town size, not just remoteness, will strongly influence variables, such as income, educational attainment, work skills and housing costs.

But our current measures are so crude that Urana, a town of 800 people in the Riverina region of New South Wales, Townsville, with around 195,000 people, and Darwin, with around 130,000 people are in the same category.

Another data set collects measures socioeconomic status. Variables used to calculate this index typically include income, internet connection, the percentage of people schooled to year 11 only, the proportion in the labour force who are unemployed, long-term health conditions or disability, and people paying less than $166 rent per week.



Graph showing the correlation between factors associated disadvantage and geographic location.

All of these are almost certain to be influenced by two characteristics of place: its distance from a capital city or other large centre, and the size of the town. The remoteness and the size of a particular community influences its access to schools, jobs and high-paid employment. Other issues, such as the nature of the main local industries, or economic drivers, such as weather, are also influential.

We can keep doing new analyses to expand our understanding of how various factors interact to cause the clear health disadvantage in rural and remote areas. These might even suggest the causes for the different but they will be misleading without a solid understanding of underlying variables.

While the role of income and education on health status are universal and universally accepted, it's too early to dismiss place – especially "rurality" – as a determinant of health status.

It seems likely that place is a primary determining factor in the worse health of rural and remote Australians, with socioeconomic status being an intermediary. In other words, low income might be the toxin, with place being what allows it to harm people.

We know socioeconomic status is a major determinant of health, but understanding how the characteristics of a particular place impact health is critically important if we are to understand how to improve health and longevity in rural and remote Australia.

ACKNOWLEDGMENT Gordon Gregory and Andrew Phillips from the National Rural Health Alliance contributed to this article.

Link to article from the Conversation
http:www. http://theconversation.com/unravelling-why-geography-is-australias-biggest-silent-killer-23238?utm_medium=email&utm_campaign=Latest+from+The+Conversation+for+13+March+2014&utm_content=Latest+from+The+Conversation+for+13+March+2014+CID_3ee2d53f04d8b9b06fcc1d2f5e13ef2f&utm_source=campaign_monitor&utm_term=Unravelling%20why%20geography%20is%20Australias%20biggest%20silent%20killer

Lesley Barclay
Professor of Rural Health
University of Sydney

Smarter Chronic Disease Management

This opinion piece by David Guest gives his reflections on the recent web based seminar on Care Planning by the Improvement Foundation and his thoughts on the changing nature of chronic disease care in Australia.

The Improvement Foundation's qiCommunity is continuing its series of webinars on Care Planning. The latest installment followed a previous session by Ros Rolleston, Practice Nurse, from the NSW South Coast. Once again Ros shared her tips and tricks for care planning. Dr Tony Lembke, APCC Clinical Chair, rounded out the one hour session with his 7(+3) CC tips.

Some suggestions that were well received were:

1. Getting the patient's agenda out as the first thing to do in the consultation
2. Getting the patient to rate their wellness on a scale of 1-10 and asking them how they feel it could be improved
3. Giving the patient their medication and history list while they are in the waiting room and getting them to update it
4. Using the same template for all chronic disease patients
5. Using motivational interviewing techniques for lifestyle changes
6. Using the patient held medical management folder as a:
    1. communication tool
    2. chore list (viz. homework)
    3. calendar for future visits and follow up

Changing Chronic Disease Management

Chronic disease is an increasing burden in all developed and developing nations. Social and environmental factors will play a more important role in its management than medical investigations and treatment.

As general practitioners, and advocates for our patients and our communities, we need to adapt our practices and procedures to better manage the changing burden of disease.

Over a decade ago the American Institute of Medicine, in their Crossing the Quality Chasm report, identified the areas for reform and the barriers to change. Don Berwick, quality improvement guru and founder of the Institute for Healthcare Improvement has briefly defined the elements of what modern disease management will entail.

Institute of Medicine, Crossing the Quality Chasm

1. Safety
2. Effectiveness
3. Patient Centredness
4. Timeliness
5. Efficiency
6. Equity

Each of these areas has myriad implications for Australian general practice but perhaps patient centredness is the primary issue where local nurses and doctors can have the greatest and most immediate impact.

There are a hundred thousand things to fix in chronic disease management. Time is of the essence.

Kevin Hogan

MP for Page

Order in the House

It has been a big fortnight for the health sector across Page.

As I am sure you would have read or heard in the media, I was successful in lobbying Health Minister Peter Dutton to find $3 million to upgrade the emergency department at Casino Hospital – that's on top of the $4.5 million to fund my election promise for an upgrade of Ballina Hospital.

The Casino hospital upgrade was originally promised by the previous government, but after touring its cramped and antiquated emergency department I decided it was crucial that it was delivered – no matter who promised it – as I believe health should always be above politics.

When construction work is finished Ballina hospital will have an extra operating theatre and expanded the medical imaging department. Casino and District Memorial Hospital emergency department will have new treatment and resuscitation bays, a new triage area and staff room, and improved ambulance entry area and waiting rooms.

Both these important upgrades will have a two-fold effect – it will give each community better health facilities, while easing pressure at Lismore Base Hospital. In short, there will be long-term benefit for locals, hospital staff, visitors to the region and new residents.

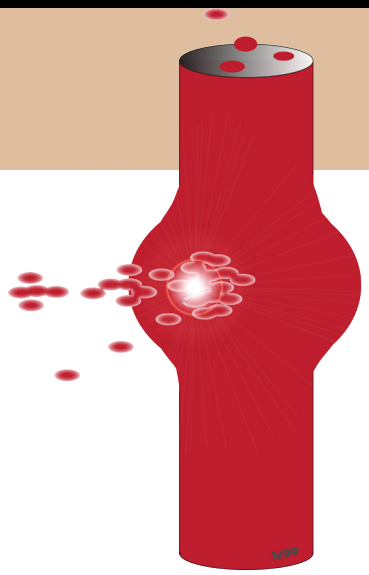
While I was lobbying Peter Dutton for the funding for Casino, I also invited him to visit Page to inspect our health facilities and meet some of our health leaders. I am delighted to say he was very happy to accept.

Health Minister Peter Dutton, Page MP Kevin Hogan and Chairman, North Coast Medicare Local , Dr Tony Lembke during the Minister's Northern Rivers visit.

The minister met members of the Page Health community and came away impressed by their desire to foster collaboration between the various services to improve patient outcomes. I'm now hopeful that when it comes to trailing a new service, Mr Dutton will look favourably upon Page.

I also took Mr Dutton to inspect the new headspace facility in Lismore, which I officially opened the next day. Mental health is an important issue in Page, particularly among our young people. I'm happy to say the determination to tackle mental health issues has bipartisan support.

Abdominal Aortic Aneurysms



Introduction:

Abdominal aortic aneurysms (AAA's) are defined as a focal dilation of the aorta beyond 150% of the normal adjacent arterial diameter, which in clinical practice is generally interpreted as greater than 30mm.

AAA's are most often asymptomatic and will continue to grow unpredictably until they reach a significant size and rupture, usually without warning and with catastrophic consequences. Non-invasive imaging, usually computed tomography (CT) scan or duplex ultrasound scan (USS), are the mainstays of AAA detection as clinical examination is notoriously unreliable. It is most often during investigations for other medical conditions that AAA's are identified. Once identified AAA may then be treated or followed (surveillance) and treated if they reach a size that requires intervention or become symptomatic.

In general, there are two main forms of surgical treatment – open aortic reconstruction or endovascular aortic repair (EVAR). Depending on open or endovascular treatments, hospital stays can be anywhere from 3 to 5 days for endovascular procedures and 1 to 3 weeks for open procedures.

Treatment of AAA's needs to be prophylactic as when rupture occurs, less than 50% of patients make it to hospital and usually 20 -30% of this group survive emergency procedures. Therefore the goal of AAA management is detection, surveillance and treatment while asymptomatic.

Epidemiology and Risk Factors:

Aneurysmal disease of the aorta is predominantly a disease of older Caucasian males and is rare under the age of 50. Women only account for 10% of AAA's, and peak incidence lags about 10 years behind males.

The incidence of new AAA's diagnosed by screening is around 5% in men aged 65-74 years with the average age at rupture being 75 years.

Aneurysms involve all segments of the arterial tree though the infra-renal aorta is most commonly affected. Approximately 5% of those with AAA will have other associated peripheral artery aneurysms, most commonly in the popliteal or common femoral arteries

Recognized risk factors for AAA include:

- Smoking
- Family history
- Male sex
- Increased age
- Hypertension
- Hypercholesterolemia
- Coronary artery disease
- Height
- Caucasian race

cont on p20

Part one of two Parts about AAA:

- ***Introduction***
- ***Epidemiology and Risk Factors***
- ***Signs and Symptoms***
- ***Assessment and Diagnostic Techniques***

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AAAs *(cont from p19)*

Interestingly, for unknown reasons, diabetes mellitus seems to be protective against AAA, reducing incidence by 50%.

Signs and Symptoms:

The majority of AAA's are clinically silent until rupture and more than 75% are diagnosed as incidental findings. In particular, clinical examination is unreliable with only 15% of AAA's greater than 4cm diagnosed by palpation. In an ever increasingly obese population, this will only become more difficult.

A minority of patients will present with a non-ruptured symptomatic aneurysm either as abdominal pain, flank pain or a change in back pain. It is worth noting that chronic back pain is a common feature of larger aneurysms and does not have the same ominous prognosis of new-onset back pain.

Less commonly embolisation from a AAA may cause "blue toe syndrome", charterized by (bilateral) digital ischemia often in the presence of good pulses. The AAA may thrombose causing bilateral lower limb ischemia. It is worth bearing in mind a proximal embolising source such as a AAA when considering a case of bilateral lower limb ischemia particularly in the absence of the usual culprit, atrial fibrillation.

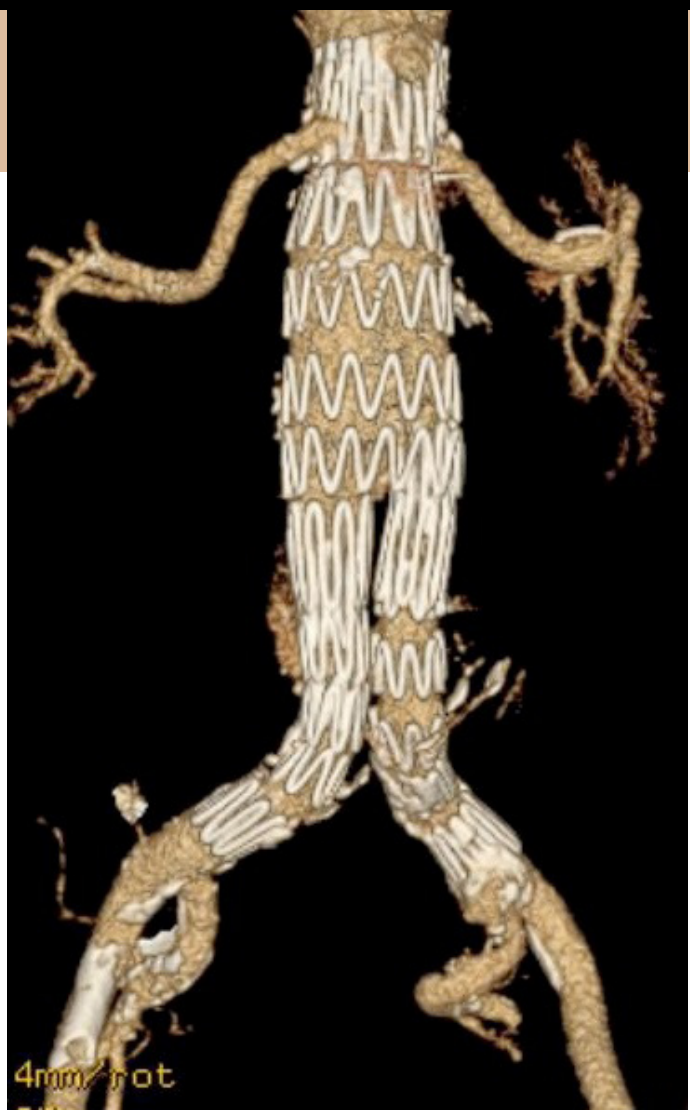
Other uncommon causes of presentation include compromise of anatomically adjacent structures including the duodenum and ureters. Compression of adjacent veins may cause iliofemoral DVT.

The most feared complication of AAA is rupture into the peritoneal cavity or retroperitoneal space, though rupture into the duodenum (aortoenteric fistula) or into the inferior vena cava (IVC) may occur, causing aortocaval fistula.

Assessment and diagnostic techniques:

1 - Duplex ultrasound

This combines B-mode or gray scale imaging with pulse-wave Doppler, which gives information on blood flow presented as color on the screen or



a wave form (spectral analysis). For AAA diagnosis, the B-mode imaging presents an accurate picture of the aorta and gives a transverse diameter. It is worth noting that USS reports often mention the length of the aneurysm – while useful for planning repairs, the length gives no prognostic information about rupture risk and it is the maximal transverse diameter that is important. Further, ultrasound can be used to exclude other causes of abdominal pain, which may be a differential diagnosis for a symptomatic AAA. The only preparation required for an abdominal ultrasound is an overnight fast.

2 - Computed Tomography Angiography (CTA)

Once an aneurysm has been diagnosed, further anatomical detail is essential in planning operative repair (if appropriate) especially if endovascular aortic repair (EVAR) is being considered, and CTA has become the imaging modality of choice.

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AAAs *(cont from p20)*

CTA requires administration of intravenous iodinated contrast media. As contrast is nephrotoxic some patients require additional measures to minimize the chance of a worsening of their renal impairment such as temporarily withholding nephrotoxic drugs such as ACE inhibitors and NSAID's, ensuring adequate oral hydration, and withholding Metformin to reduce incidence of lactic acidosis. This, combined with the use of newer iso-osmolar contrast agents has reduced the incidence of contrast nephrotoxicity to less than 1%. In those with more severe renal impairment, admission to hospital for intravenous isotonic saline hydration and administration of oral n-acetyl cysteine is often employed. No oral contrast is used for a CTA and no fasting is required.

In the next issue of GPSpeak:

- ***Screening***
- ***Medical Management of AAA***
- ***When to refer***
- ***Post-operative Care***
- ***Surgical Management of AAA***

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Suggested Reading about AAAs

1 - Multicentre Aneurysm Screening Study Group. *The multicentre aneurysm screening study (MASS) into the effect of abdominal aortic aneurysm screening on mortality in men: a randomised controlled trial.* Lancet 2002; 360: 1531 – 1539.

2 - Frank A Lederle, Samuel E Wilson, Gary R Johnson, Donovan B Reinke, et al. *Immediate repair compared with surveillance of small abdominal aortic aneurysms.*

The New England Journal of Medicine. Boston: May 9, 2002. Vol. 346, Iss. 19; pg. 1437

3 - Ballard DJ, Filardo G, Fowkes G, Powell JT. *Surgery for small asymptomatic abdominal aortic aneurysms.* Cochrane Database of Systematic Reviews 2008

4 - EVAR trial participants. *Endovascular aneurysm repair versus open repair in patients with abdominal aortic aneurysm (EVAR trial 1): randomised controlled trial.* Lancet 2005; 365: 2179 – 2186.

5 - J May, G H White, J P Harris . *Complications of Aortic Endografting*
Journal of Cardiovascular Surgery; Aug 2005; 46, 4

6 - Cross J,Gurusamy K,Gadhvi V,Simring D et al. *Fenestrated endovascular aneurysm repair.* British Journal of Surgery, February 2012, vol./is. 99/2(152-9), 1365-2168

a Tale of Two Galleries

The Museum of Old and New Art

GPSpeak's Angela Bettess visits the recently opened Margaret Olley Art Centre at Tweed River Gallery in Murwillumbah, while Robin Osborne takes in the Museum of Old and New Art (MONA) in Hobart.

'God' was apparently out on the day I visited Hobart's Museum of Old and New Art (MONA), although 'God's Mistress' was at home, judging from the Mercedes coupe in the adjacent dedicated spot in the staff car park.

In late March, God made a decent woman of his Mistress, but there were no reports on how anyone viewed the union, as one of the most publicity-savvy people in town kept the media away, the only press mention being that the outdoors ceremony was to be moved to the MONA chapel because of expected rain.

God, in this setting, is David Walsh, a fabulously successful gambler who developed a private gallery that has done as much to put Hobart on the tourist map as the site of the Port Arthur penal settlement, and a mass shooting in 1996.

The fortune that Walsh invested in the design and construction of the building, and the eclectic works that fill it, came from his involvement with a mathematical syndicate that set up above a Hobart pub and pulled off a series of Keno jackpots before blitzing the world's casinos (from most of which they are now banned).

Despite jousts with the tax office, and his outspoken predilection for group sex, Walsh can do no wrong in the eyes of Tasmanians, both the common folk and those who run the straitened state.

Everyone values MONA for its boldness and tourist pull, while the 'bread and circuses' boon for local residents includes free gallery entry, market fairs on its spectacular lawns, and a mid-winter festival, Dark MOFO, which brings visitors at a time when most mainlanders might prefer to be tucked up warmly in bed.

Walsh, according to Wikipedia, wanted a building that "could sneak up on visitors rather than broadcast its presence ... 'a sense of danger' that would enliven the experience of viewing art".

Certainly the best way to approach it is on MONA's camouflage-painted 'MR-1' fast ferry – take the 'posh pit' option if you wish, with canapes, pastries, coffee, wine from their own vineyard or Moo-Brew beer from their brewery.

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a Tale of Two Galleries

MONA *(cont from p22)*

by Robin Osborne

Get the picture? This gallery aims to be different, an admirable artistic ambition, but in my view it tries too hard.

There's no doubt that the structure, built into and below the stone cliff face is extraordinary, resembling, said one observer (again, Wikipedia), as like "going down into Petra", the fabulous ancient city in Jordan (which is truly far grander).

So, to the collection, which, as a friend reminded me, must be regarded as a private one reflecting personal tastes, not that of a state-run gallery.

There is plenty of ooh-aah upon entry, especially for the light-show waterfall, and then for the standouts, such as the Egyptian mummy in the darkened death chamber, and MONA's signature 'poo machine', the Cloaca Professional, 2010 by Belgium artist Wim Delvoye.

This basement level installation is a production line that turns the food it is given at one end into faeces of great integrity at the other. You can watch the clip, although not get the smell-o-vision, which lingers in the nostrils, at https://www.youtube.com/watch?v=InmrF-7xCvo

The collection, estimated value $100M, includes ancient sarcophagi, works by Aboriginal artist Rover Thomas, coins, beetles, modern furniture and contemporary art, video works and light shows, and a great deal in between, all displayed imaginatively on three cave-like levels.

What, then, is lacking?

Apart from soul, it also does little to reflect Tasmanian spirit-of-place, despite the fabulous setting. Given MONA's taste for the bizarre, not least the dead, I expected a thylacine presence, considering you see them on beer labels, car number plates, the state government logo, and so on.

But for an actual Tassie Tiger, albeit stuffed, you need to visit the Tasmanian Museum and Art Gallery, near Constitution Dock where the MR-1 begins its riverine journey.

A typical 'sandstone' institution, TMAG includes a 'tiger' room displaying well-preserved thylacines and other sad memorabilia such as the documentary footage of the last animal in captivity, endlessly pacing its zoo cage.

The attempted wiping out of the Aboriginal population is the subject of a well-designed historical display, along with a superb collection of contemporary Tasmanian artworks in various media. The quality of these was unrivalled by almost anything I saw in MONA.

As they say, money can buy you everything but taste, and while winning from the losings of others enabled 'God' to obtain the right design and construction team, I'm not convinced that his artistic Xanadu – where he and Mrs God live – is quite as heavenly as it might be.

a Tale of Two Galleries

Portrait of the artist as a Sydney woman

A visit to the Tweed Regional Gallery at Murwillumbah is a must for artists, art lovers and historians, in fact anyone with an eye for beauty and a curiosity about the creative process.

The transported interiors of Margaret Olley's house in the inner Sydney suburb of Paddington show a plethora of flowers, objets d'art, furniture, even a plate of cigarette butts in the fabled 'yellow room' (not named from the many years of nicotine exposure). The gallery has accomplished a timeless portrait of Margaret Olley, the grande dame of Australian art, by bringing her studio to viewers in the region where she spent her younger formative years.

Margaret Olley was born in Lismore (1923) and died in Paddington (2011). Portraits of her – rather than by her - were winners of two Archibald Prizes - in 1948 by William Dobell, and by acclaimed current artist Ben Quilty in 2011. Olley received many awards in relation to her life-long commitment as an artist and the promotion of art, including 1991 Officer of the Order of Australia, 2006 Australia's Companion of the Order and in 2006 a Doctor of Fine Arts honoris causa degree from the University of Newcastle.

Interior view of the Hat Factory recreation at the Margaret Olley Art Centre courtesy of the Tweed Regional Gallery

After Lismore her family moved to Northern Queensland. In the 1930s , they returned to the Northern Rivers and lived on a sugarcane farm at Tygalgah, north of the Tweed River and Murwillumbah. During these times, her absorption of farm life laid the foundations for her love of nature and natural surroundings. She attended Brisbane's Somerville House as a boarder, then Brisbane Central Technical College and later went to East Sydney Technical College, the city's main art school. Her passion for painting became her life.

Olley is known mostly as a painter of interiors and still lifes. Many of her paintings are compositions of flowers, fruit and common objects such as jugs, glasses and vases - but all have a sense of the human element contained within them. Her Paddington home studio included an ex-hat factory room and her favourite Yellow Room where many of her oil paintings on board were painted.

With grant assistance, Tweed Regional Gallery undertook the major task – unprecedented in the Australian art world, the nearest resemblance being the preservation of Brett Whiteley's Surry Hills studio – of relocating the key areas of her Paddington home and studio to the North Coast.

The challenging process, which has been achieved so brilliantly, required a process of cataloguing the contents, then carefully transporting them up to the Gallery for public exhibition. This extraordinary permanent display opened in March. Visitors view the Margaret Olley Art Centre through cleverly constructed visual ports and doorways, feasting their eyes on the yellow room, the green kitchen area and the hat factory, all meticulously reconstructed.

Margaret Olley's life was her art, and vice versa, and together they provide an intimate view of one of our nation's greatest painters and the cluttered domestic world that fostered her creations.

Food Exposure Counts - 15 times

Adelle Purbrick of Body Balance Nutrition gives advice to those who cook for fussy infants and husbands.

Did you know a child (or even adult) needs to be exposed to a new food up to 15 times before it is trusted, and a further 10-15 times before it is liked! But parents often give up after five attempts!

The number of food exposures needed tends to increase with age e.g. a two year old may need 5-10 food exposures, while those older than four may need 10-15 food exposures.

So if you are still struggling to get your child to eat their veggies, or anything at all, keep offering them. Chances are you have not offered the food 15 times!

Even if the food is not actually on the child's plate, exposure can include mum and dad eating the food in front of the child while all sharing a meal together. The foods on the table in serving bowls so that the child can 'choose' them if they want to. Also the foods can be on a 'trying' plate next to the child's own plate.

Adelle Purbrick

A confession - this is advice I will try to remember this advice when I am contemplating broccoli for what feels like the 100th time!

For more information or advice contact an Accredited Practising Dietitian.

References:

1. Howard et al, Appetite 59, (2012), 818-825. NOURISH RCT.

2. Mitchell G, Farrow C, Haycraft E , Meyer C. Parental influences on children's eating behavior and characteristics of successful parent focused interventions. Appetite, 60, 2013, 85-94.

Vax 'skeptics' choose a new name

The new name chosen by the Bangalow-based group that opposes vaccination against infectious disease has been endorsed by the NSW Fair Trading Minister, Stuart Ayres.

Formerly known by names such as the Vaccination Awareness Network, and the Australian Vaccination Network, which implied support for vaccination, or at least a balanced view, the group will now be known as the Australian Vaccination-Skeptics Network (AVSN).

While not making clear that vaccination is actively opposed, the name is intended to appease the many complainants – including the AMA - who had raised concerns about the group's misleading profile, and public campaigning.

This led to the involvement of Fair Trading, which decreed a name change, and a subsequent appeal by the group to the Administrative Decisions Tribunal, which said that using such words as 'risk' or 'sceptics' would be acceptable.

AVSN said it was forced to use the American spelling of sceptics after 'hate groups' had prevented it registering 'Australian Vaccination Sceptics Network'.

An amended website, stationery and other material is now being developed, it added, with high-profile member Meryl Dorey saying the name change would have "no effect whatsoever… I don't think anyone was confused about what our organisation stood for."

Minister Ayres welcomed the group being "up-front" about its stance.

"I am pleased to see the association has adopted a name which reflects its purpose, given its overwhelming focus on the publication of anti-vaccination messages and information," he told the AAP service.

Unbridled Enthusiasm ... and Then

In April 2008, flushed by its landslide victory in November 2007 election, the new Rudd government brought together a range of people prominent in their field – Cate Blanchett being the most remarked upon - to examine ten critical areas for the future of the nation.

The first seven of the areas (infra vide) featuring in the 2020 Summit had direct clinical or business impacts for rural medical practitioners.

These were exciting times, full of great hope, and there was a sense that significant change was on the way. In May 2010, the final report was released. Of the 138 recommendations put forward, just three were adopted.

Tony Abbott and the Liberal National coalition swept to power in September 2013. As previously, the new government has initiated a number of reviews to set the agenda for the future. Since the financial landscape has changed significantly in the last six years, the new government's focus is on cost cutting and efficiency. A number of Agencies and Commissions have been closed and many of the reviews have been already been delivered to the government so that they can be digested by Treasury and the Expenditure Review Committee prior to the Coalition's first Budget, due in late May 2014.

This time around there has been no love-in. The National Commission of Audit will report in a few weeks and provide the overall framework for the Government's spending options. It is unlikely to be released to the public before the Budget.

In the Health portfolio, the Royale report into the troubled Personally Controlled Electronic Health Record, which was delivered before Christmas, has also not been made public. Options for tinkering with demand for GP services by introducing a small co-payment have been much discussed in the media but may turn out to be a furphy. Rumours about means testing the Commonwealth Seniors Card have surfaced more

"feeding the chooks"

recently. This too would have an impact on demand for medical services. Ironically, Dr Steven Hambleton, AMA president and co-author of the PCEHR report, has called on the government for the release of the Seniors Card Report. "The whole thing should be released so people can assist the government in making appropriate decisions." It would appear the government does not need any help.

The Abbott government's approach to public discussion has been compared to the Bjelke-Petersen government's communications strategies of the 1980s. However, in these modern times, 'feeding the chooks' involves battery farming and a

cont on p 27

"Feeding the Chooks"

(cont from p26)

marked reduction in feed allotment.

So what does the future hold for electronic medical communication in Australia? We have peered deeply into the entrails but have not divined a pattern.

The PCEHR's main premise was that communication would flow from point to portal. While noting claims to the contrary, it is entirely feasible that the PCEHR could have been the ultimate source of truth for some aspects of medical care such as medication management. However, despite the best technical and legal efforts, it is now obvious that a portal can never be as secure as locally held records.

Point to point communication appears to be back in favour, at least for this revolution of the political cycle. It might be dull and traditional but is a model well understood by medical practitioners and fits with their concept of medical care.

The challenge for the new government will be to leverage the significant investment already made in the health authentication infrastructure and to find a workable model for message exchange between the companies providing "last mile" message delivery. Many of the financial issues in this area have parallels with general data exchange on the Internet. (See Interconnect agreements) However, the market has failed to resolve these issues for over ten years under both Labor and Liberal governments.

Strong leadership is needed to find a solution to this vexing problem. Peter Dutton is the new Health Minister. With a background in small business he espouses the Abbott government's ethos of hard work, self-reliance, independence and productivity. He is on the Expenditure Review Committee.

Politics may well be "the art of the possible," but conversely, "war is the continuation of politics by other means". It remains to be seen which outcome eventuates when – or if? – the Minister begins dealing with the big end of town..

2020 Summit - 10 Critical Policy Areas

1. Productivity—including education, skills, training, science and innovation.
2. Economy—including infrastructure and the digital economy.
3. Sustainability and climate change.
4. Rural Australia—focusing on industries and communities.
5. Health and ageing.
6. Communities and families.
7. Indigenous Australia.
8. Creative Australia—the arts, film and design.
9. Australian governance, democracy and citizenship.
10. Security and prosperity—including foreign affairs and trade.

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

Ultrasound Guided Bursal Injections

Before proceeding to any interventional procedure, a detailed imaging examination of the affected area should be performed. This may include ultrasound, xray or MRI.

Where a thickened bursa is present, a steroid and local anaesthetic injection using ultrasound guidance is a precise option for treatment. The benefit of using ultrasound is that this gives a real time visualisation of the needle as it enters the bursa.

Subacromial bursitis

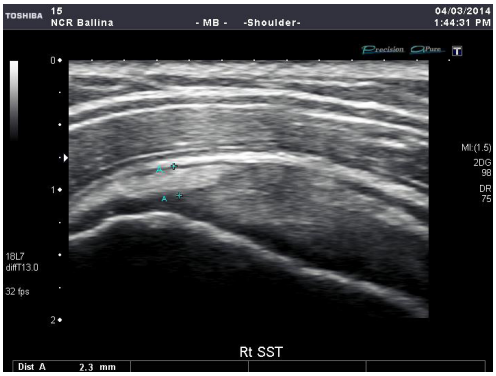


Image 1A Subacromial bursitis. The image demonstrates a thickened bursa which is easily diagnosed on ultrasound.

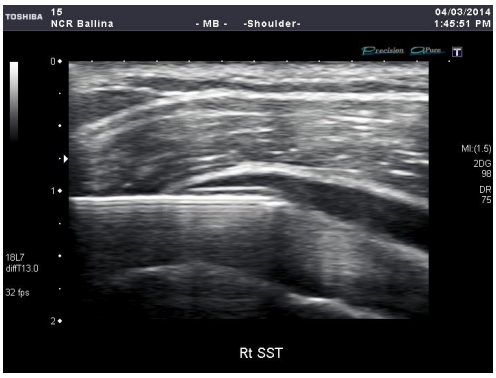


Image1B shows, using a real-time ultrasound technique, the needle placed in the exact location required. Precise needle positioning with millimetre accuracy is achievable.

Image 1B Ultrasound Image clearly showing the location of the needle into the thickened bursa.

The benefit for this patient was a significant decrease in pain and significant increase in the range of movement.

by Mark Bryant , Senior Sonographer
North Coast Radiology

Trochanteric bursitis

This patient presented with trochanteric bursitis. There is a lot of adipose tissue to penetrate making accurate placement of the needle difficult. However, under ultrasound accurate placement of the needle was achievable.

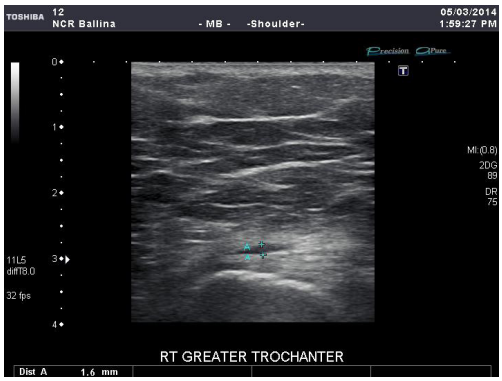


Image2A Right greater trochanter showing bursa location

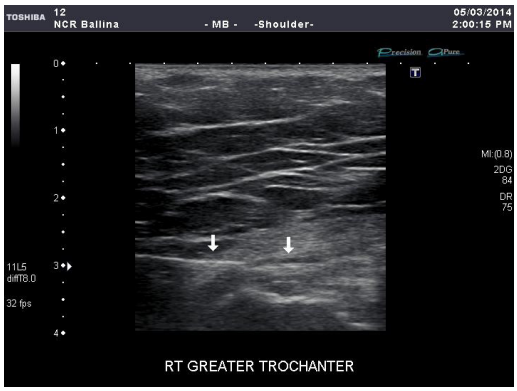


Image 2B The needle is clearly visible as it moves towards the bursa

With this level of accuracy, patients are less likely to be subject to painful repositioning. of the needle. Also the free passage of steroid and local anaesthetic around the bursa can be observed in real time. Skilled professionals are able to perform these injections easily with great accuracy . Therefore, the benefits to patient care are clear to see.

NORTH COAST Radiology Group
Serving our community since 1974

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.

Public Health Alerts Vital Before Heatwaves

While the impact of unusual heat events on people with serious illness such as cardio-vascular disease cannot be eliminated, the risks of extreme temperatures over one or more days can be reduced by following public health messages offering simple, practical advice.

This is the central recommendation of a research study* by a group of leading Australian scientists, including Dr Geoff Morgan, epidemiologist from The University of Sydney, based at the University Centre for Rural Health North Coast in Lismore.

"The study examined the association between unusually high temperatures, daily mortality (death) and hospital admissions in the Sydney Greater Metropolitan Region over a ten-year period up to 2010," Dr Morgan explained.

"The aim was to assist in the development of targeted public health programs designed to minimise the impact of extreme heat on health."

The study focused on the Sydney/Illawarra/Lower Hunter region. Heat-events were based on the daily maximum temperature and defined as 'severe' (on average nine days per year) or 'extreme' (on average two days per year).

The researchers concluded that both single and multiple-day severe and extreme heat events were associated with significant increases in mortality and hospital admissions.

The results suggest that severe and extreme heat events may lead to a rapid deterioration in persons with existing cardio-vascular disease, resulting in death.

As the weather cannot be controlled, they concluded that targeted public health messages are important to reduce the adverse effects of high temperatures.

The North Coast of NSW experiences periods of high temperatures similar to those assessed in the Sydney study, and so the same advice applies locally.

According to Dr Morgan, timely messages during periods of unusually high temperature

would target vulnerable groups such as the elderly, infants and young children, people with pre-existing medical conditions, people living by themselves or socially isolated.

Such groups can reduce their health risk by:

- drinking plenty of water
- keeping cool and keeping your house cool
- taking care of others

For more information see NSW Ministry of Health's Beat the Heat information at: *http://www.health.nsw.gov.au/environment/beattheheat/Pages/default.aspx.*

**** The impact of heat on mortality and morbidity in the Greater Metropolitan Sydney Region: a case crossover analysis, Environmental Health 2013 12:98 pp2-14***

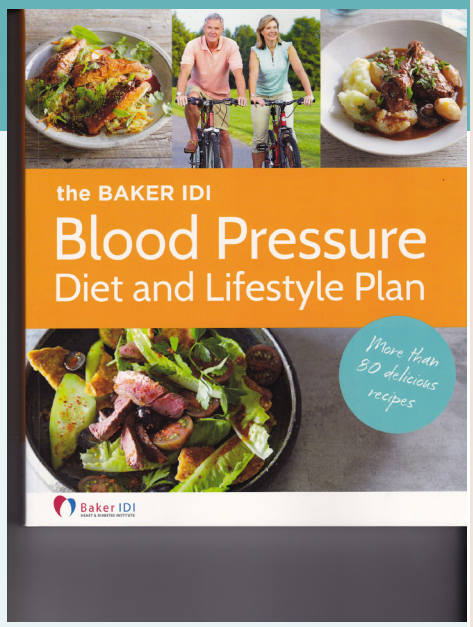
UNIVERSITY CENTRE FOR RURAL HEALTH NORTH COAST
education research workforce

Book Reviews

by Robin Osborne

The Baker IDI Blood Pressure Diet and Lifestyle Plan

Penguin $35.00



Who better to produce a book on healthy living and blood pressure management than Baker IDI Heart and Diabetes Institute, the internationally known body working on the diagnosis, prevention and treatment of diabetes and cardiovascular disease?

Firstly, it is a magnificent production to behold, published in full-gloss and weighing in at around kilogram, although a soft-cover. The content justifies the style, as a quick glance confirms.

Describing the 'epidemic' of high blood pressure, or hypertension, as a largely silent one, the organisation's head of preventative health, Prof Simon Stewart, notes in his foreword that, "If you're overweight, eat poorly, don't exercise regularly and/or have a pre-existing condition such as diabetes and/or heart disease, there are good reasons for you to have your blood pressure checked by your GP."

While that's the first important step, next comes the need for healthy lifestyle maintenance, which is where this book will be so helpful.

Prof Stewart writes that leading heart disease and nutrition experts have come together to create a book that includes the ideal targets that individuals and their healthcare teams should aim for.

It offers, amongst the many pictures of beautifully prepared meals and menu plans both practical and delicious, "important advice on the treatment you might be prescribed if you have high blood pressure, and the benefits of simple but highly effective lifestyle changes you can make to improve your overall health."

In precise yet readily understood language, well supported by photos and diagrams, the book explains blood pressure diagnosis and management, the importance of exercise and the best ways of getting it, and provides a host of healthy recipes.

Baker IDI, the authors (Prof Garry Jennings, Prof Peter Clifton and Assoc Prof Jennifer Keogh) and the publishers are to be congratulated on this excellent contribution to living well.

The Emperor of All Maladies

Siddhartha Mukherjee
Publisher: 4th Estate

In his 2011 'biography of cancer', widely acclaimed as essential reading for clinicians, cancer patients and supporters, Siddhartha Mukherjee discusses a group of British surgeons, who, in 1933, considered carcinoma of the stomach in terms of an old Arabian proverb, "He is no physician who has not slain many patients…"

As Dr Mukherjee adds, to arrive at that kind of logic is to invert the Hippocratic Oath, but it is hardly the language we hear these days from medical practitioners.

Although a cancer diagnosis, especially an early one, is no longer a death sentence that may justify experimentation, the incidence of cancer continues to rise in certain nations, including Australia, creeping inexorably, as the author puts it, from one-in-four to one-in-three, and now to one-in-two.

Recalling a patient's description of her condition, Dr Mukherjee, an oncologist and haematologist, and assistant professor at Columbia University, agrees that cancer is becoming "the new normal …an inevitability," adding that the question is not be if we will encounter this immortal illness in our lives, but when.

The 570-page work has since won a Pulitzer Prize for non-fic-

cont on p 33

Book Reviews (cont from p32)

by Robin Osborne

tion, being named as one of the 100 most influential books written in English since 1923 by Time magazine.

Addressing one of modern medicine's most complex challenges, he writes, "That this seemingly simple mechanism – cell growth without barriers – can lie at the heart of this grotesque and multifaceted illness is a testament to the unfathomable power of cell growth…. Cancer cells are more perfect versions of ourselves."

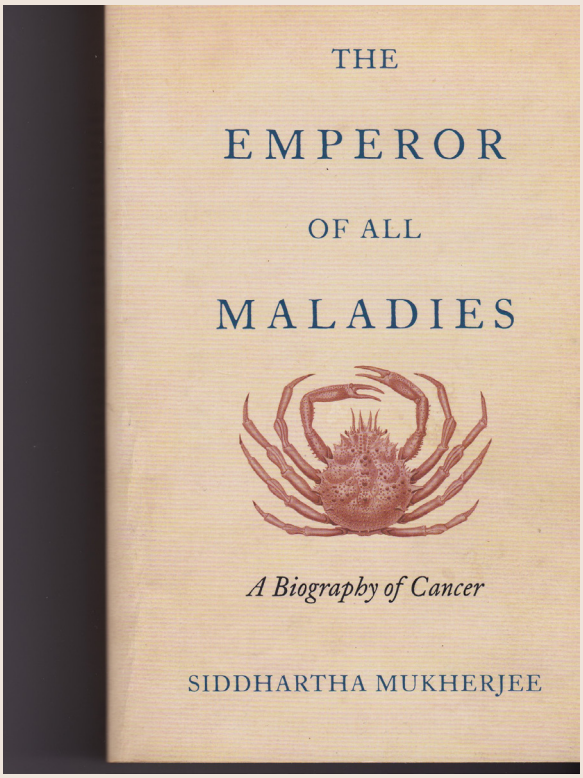
Dr Mukherjee continues, "The secret to battling cancer… is to find means to prevent… mutations from occurring in susceptible cells, or to find means to eliminate the mutated cells from compromising normal growth. The conciseness of that statement belies the enormity of the task.

"Malignant growth and normal growth are so genetically intertwined that unbraiding the two might be one of the most significant scientific challenges faced by our species."

The journey begins from early records such as the description on a 17th century BC Egyptian papyrus of "bulging tumours on the breast", and extends to the present day. It encompasses public health research on cancer, notably the work of Doll and Hill on the smoking connection, the efforts to prise more funding from government coffers and private purses, the decades of lab work, and the vast treatment continuum, from surgery, in both its 'radical' and less invasive forms, through to radiation and chemical therapies.

Woven through this complex narrative are Dr Mukherjee's experiences with many of his own patients. These interactions, often immensely painful to him, make it clear that he is not just a clinician, or researcher/writer, who observes the terrain from afar.

Like the book itself, cancer, in the words of oncologist Harold Burstein, "resides at the interface between society and science… forcing us to confront our customs, rituals, and behaviours."



Meanwhile, researchers and practitioners around the world are striving to find ways of toppling this 'emperor of all maladies' from its throne.

No doubt one of the answers, perhaps the main one, in encapsulated in part four (of six) in the book, Prevention is the Cure, beginning with an apt quote from the Chicago Tribune in 1975: " The idea of preventive medicine is faintly un-American. It means, first, recognising that the enemy is us."

Of course, this assumes that all sectors of society – and not just in the USA - are capable of acting rationally in regard to lifestyle behaviours such as diet, exercise, tobacco and alcohol consumption, and so on.

Our widespread inability/unwillingness to do so will continue to impact on the incidence, and consequent impact, of cancers as well as a range of other serious illnesses, much to the detriment of individuals and the health system at large.

To over-simplify, there is a strong case for urging, "Citizen, health thyself," and for government to support this endeavour where appropriate.