GPSpeak

Journal of Northern Rivers General Practice Network

SPECIAL FEATURE

Pedalling perils -
the risks (and joys) of cycling

September - October 2014

GPSpeak
Journal of the Northern Rivers General Practice Network

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

Proudly supported by...

Contents

Cover photo: ***Cyclists take the Clarendon Hotel corner during the Village Fair and National Penny Farthing Championships in the picturesque Tasmanian village of Evandale. Since 1983 penny farthing enthusiasts have converged on the area from around Australia and overseas to contest a series of weekend races. The event is recognised as the largest annual gathering in the world devoted to racing antique bicycles. The penny farthing, which received its nickname from English copper coins, was popular until the development of the 'safety bicycle' in the 1880s.***

Photo courtesy of Hobart-based photographer Rob Walls.

Editorial

Dr David Guest
NRGPN Chair

In a reversal of the self-destructive rock 'n roll adage of "live fast, die young and have a good looking corpse", the modern medical system is focused on encouraging us to live wisely and assisting us to progress into late age, now longer than ever in human history. The new mantra might be "live long, die fast but still have a good looking corpse".

The emphasis on longevity is combined with the almost universal hope that we can also enjoy our later years, free of both pain and chronic illness. While doctors may speak of maximising quality adjusted life years (**QALYs**) epidemiological terminology never has the same "cut through". The effects of alcohol and smoking on lung and heart disease are well known, but these key lifestyle factors, along with poor diet and inactivity, are the preventable causes of one **third of cancer deaths**.

In this issue of GPSpeak, **Jasmin Ritchie of Embrace Exercise** reminds us that 20 per cent of coronary heart disease world wide has been attributed to physical inactivity. Cardiac and pulmonary rehabilitation services have contributed significantly to restoring patients' confidence to manage at home after a period of hospitalisation. However, social isolation and depression can contribute to a failure to maintain an exercise program and a downward spiral in the patient's health leading to worsening disability and death. Regular review of an exercise program, particularly if it can be linked to a group exercise program, appears to have a beneficial effect on keeping people in the community and healthy.

Adelle Purbrick of Body Balance Nutrition helps us digest the National Heart Foundation's alphabet soup of Omega-3 recommendations. If you don't know your ALA from your EPA and DHA, she can enlighten you. If you like your tofu (firm or soft), you are probably already on top of the game. For the rest of us it's fish and eggs (omega-3 enriched) on linseed toast with canola margarine..

Dr Andrew Binns notes that many end of life treatments are futile, expensive and sometimes painful. Establishing and regularly reviewing a patient's end of life care plan is an essential part of aged care. He recommends the MyChoice program first established by the NRGPN several years ago. This, along with a large array of other resources for **Advanced Care Planning**, are available on the NCML's 'Healthy North Coast' website.

This issue focuses on the perils and the pitfalls of cycling in Australia over the last 100 years. While bikes and roads have improved significantly, the motor car has replaced the horse as the most disastrous encounter for a cyclist. Dedicated cycleways, such as those discussed by Lismore Mayor, Jenny Dowell, help to reduce risk but limited funding slows progress in their construction. Avid cyclists Max Osborne, Andrew Binns and Chris Gavaghan give their various perspectives, with Darryl Pursey, the master of the local cycling fraternity, offering some practical tips for minimising risks on the road. Finally, former cyclist Charlie Hew, one of our local GPs, shows there is more than one way to cover 90 kilometres. Competing in the South African Comrades Ultra Marathon is definitely not for the faint-hearted.

All stories in GPSpeak are archived on the **GPSpeak website**. The search box found in the top right corner of every page is an excellent way for finding an old article. If you cannot recall the MBS approved GP indications for ordering a MRI, type in "MRI" in the search box. Alternatively, if you want to know about this thing called kaizen, check it and the associated links out through a GPSpeak search.

The northern hemisphere summer has drawn to a close. As I write, the Grand Slam tennis circuit has nearly ended, the World Cup is a wonderful memory, ditto the Commonwealth Games. The cycling tragics have **endured the long cold nights** of the Tour de France, and now Spring is in their step. It's time to get going again - "On yer bike"… but watch out for the swooping magpies ... and the errant drivers on our potholed rural roads.

THE SPECIALISTS IN HEALTH

Your Health is our Total Concern

NEW

Doff N' Donner
puts compression garments on safely and in minutes.

SOUTHSIDE HEALTH & HIRE CENTRE

Southside Pharmacy
13 Casino Street,
South Lismore 2480
Local D.V.A. RAP Supplier

Ph 0266 214440 Fax 0266 214447
Email: health.sspharmacy@westnet.com.au
Web: www.southsidehealthandhire.com.au

Fisher & Paykel HEALTHCARE

C.P.A.P SUPPLIER

Perso packing
Medication reviews
Open until 6pm weekdays

Nurses on duty weekdays

FITNESS & REHAB EQUIPMENT

HOSPITAL EQUIPMENT AT HOME INCLUDING A SPECIALISED BARIATRIC RANGE

HIRE WITH AN OPTION TO BUY

Best Practice for End of Life Care

Andrew Binns reflects on the achievements of the MyChoice program after three years' operating in general practice.

In the past, Palliative Care (PC) has tended to focus on terminal cancer, but as general practitioners well know, patients with other non-malignant chronic diseases also need a primary care team approach to support the complex needs of providing terminal care. In 2010/2011 the Northern Rivers GP Network was commissioned to undertake a 12-month Rural Palliative Care Project aimed at addressing best practice end of life care for sufferers of a chronic disease.

Badged 'MyChoice', it was aimed at developing a framework for managing end of life care. The intention was to give patients the opportunity to articulate their choices and enhance the control they have over their terminal care. The project officer (PC Clinical Nurse Consultant Kate Stirling) led the way in developing this document in consultation with local GPs and the NCAHS PC team based at St Vincent's Private Hospital Lismore.

An **excellent resource manual** was the result.

Step 1 described a process for initially identifying the clinical indicators as to who should be classified as a PC patient. They are then registered as such in the practice medical record system. An Advanced Care Directive (ACD) is recommended, for which a MyChoice template is provided. This is very clear and easy to follow - unlike many others available.

Step 2 is to assess the patient and carer needs; this is a questionnaire to be filled out by the patient, with carer input as needed.

Step 3 is to develop a GP management plan and/or a team care arrangement with appropriate referrals made to the local Specialist Palliative Care Service (SPCS) when needed. Practice nurses can play a major role in developing these arrangements. To have a framework to use is very helpful for both GPs and the team they work with.

These three steps were based on the Gold Standards Framework © developed in the UK more than a decade ago. It is a systematic approach to providing best practice for end of life care, regardless of diagnosis. It has had strong support from GPs in the UK, and with some adaptations the MyChoice project is well suited to practices here. Chronic care management support systems through Medicare help fund the implementation of these steps.

It is estimated that currently two-thirds of patients whose death is expected are managed solely by primary care providers. The remaining one-third may either require occasional input from a SPCS or have complex needs and require ongoing SPCS involve-

(cont on p6)

End of Life Care (cont from p5)

ment. (Palliative Care Australia 2005. A Guide to Palliative Care Service Development: A population based approach)

End of life care requires a team approach. Those who choose to die at home need to have a GP prepared to do home visits.

During 2013, North Coast GP Training (NCGPT), the Northern NSW LHD and the North Coast NSW Medicare Local (NCML) collaborated in a pilot scheme to providing a GP registrar to assist GPs in looking after their end of life patients under the clinical supervision of the PC Staff Specialist (currently Dr Ken Marr), could make a difference to:

1. The proportion of patients who fulfill their wish to die at home when this is manageable.

2. The number of days admitted to hospital between referral to the service and death.

3. The number of hospital admissions between referral to the service and death.

4. The number of completed Advance Care Directives

The initial pilot was funded by the NNSW LHD and NCML, with support for research from Australian General Practice Training and NCGPT. The role of the GP Registrar PC facilitator was to initiate advance care planning by conducting an initial patient evaluation and subsequently providing ongoing home visits in liaison with the palliative care team at the request of the patient's GP.

It also focused on increased support for clients in the home setting during the terminal phase by providing a formalised end of life planning service and regular medical review in the terminal phase.

Two GP registrars with an interest and training in palliative care were recruited to the role as part of their training.

GPs in a specific geographical area were invited to refer appropriate palliative patients to this service, while retaining the role of the principal treating doctor. Data collected was compared to data collected in the same time period from another geographical area in the Richmond catchment area.

Anecdotal reports from referring GPs, patients and carers were overwhelmingly positive and the interim data on home death rates, hospital admissions and bed days and ACD completion rates have been significantly better in the group receiving the additional service. For this reason the project has been extended for another year.

It is well known that end of life care in hospitals can result in inappropriate, futile and costly clinical intervention. To have a framework to manage such patients according to their wishes, whether at home or hospital with appropriate GP and PC team support, is good clinical practice. At the same time there are potentially significant cost savings for the health system.

Pedal pushing is on a roll

A 39-year-old Coorabell woman is in a Brisbane hospital with head and leg injuries after the bicycle she was riding was involved in an accident on Ewingsdale Road near Byron Bay on Wednesday night… The latest accident on that road has sparked a warning by a local cycle club that another cyclist could be killed there unless the cycleway is upgraded all the way to the highway from Byron Bay.
Four cyclists have been injured in accidents on Ewingsdale Road west of McGettigans Lane in the past three years.
Byron Bay Cycle Club told APN Media that Wednesday night's incident came six months after a well-known local cyclist was killed while cycling along Ewingsdale Rd.

Robin Osborne
Editor GPSpeak

There's no doubt that cycling is on a roll, with a boom in bike sales around the country and unprecedented interest in international events, notably the Tour de France, these days (or more accurately nights) televised live in its entirety.

That cycling has a range of health benefits is well known and indisputable, but the down side – quite literally – is that riders are highly vulnerable to serious injury as a result of poor road conditions and the risks posed by motorised traffic.

In a recent profile in *The Australian Financial Review,* the race director for 'Endure for a Cure', Christopher White was asked what would be the one thing he would do to improve the world of cycling. He responded: "The relationship between all road users".

Alas, news reports such as that above are all too common, both in the Northern Rivers, where several have occurred in recent weeks, and elsewhere in Australia.

While the behavior of drivers often leave much to be desired, cyclists can also play a role in making our roads safer, not least for themselves, as Associate Professor Craig Fry, Centre for Cultural Diversity and Wellbeing at Victoria University, wrote in *The Conversation* 16/7/14 - **Cyclists can do more to be safer on the road**

So, too, can the media, which often portrays a negative view of cyclists and in so doing contributes to the poor, or downright dangerous, behaviour of drivers.

"I suspect if you asked, most regular riders would tell you negative media about cyclists can indeed influence driver behaviour," wrote Assoc Prof Fry, who averages ten hours on the road each week.

"I have had my own experience of this, the day after the 2012 incident in Melbourne involving an altercation between Shane Warne and a cyclist.

"While cycling to work I encountered a taxi driver who had obviously been influenced by the media attention around the Warne story. He pulled up next to me at an intersection, tooted his horn, wound down his window and shouted: "Warney was right! Why don't you get off the road you idiot!"

"Next to him was his passenger, an elderly lady, nodding her head in vigorous agreement. I sat there stunned as the taxi driver sped off shaking his fist triumphantly."

While agreeing with the sentiments in an open letter from Safe Cycling Australia to the Australian media, Assoc Prof added, "If I am being honest though, in my 20-plus years of riding on Melbourne's roads, I have found the vast majority of drivers do the right thing when it comes to cyclists. Most drivers are sensible and respectful… The vast majority of cycling trips made each day in the world are positive, enjoyable, and worthwhile – the benefits of cycling

(cont on p8)

Pedal Pushing (cont from p7)

far outweigh the risks and harms."

In his view, the balance would be even more favourable if cyclists avoided the following behaviours -

- disobeying road rules such as running red lights
- abuse of drivers and pedestrians
- riding at high speeds on footpaths or shared pedestrian-bike paths
- failing to signal directional changes or approaches to other riders and pedestrians (such as hand signals, vocal warnings, bike bell)
- wearing earphones or headphones while riding
- riding into tight spaces and weaving in between moving cars
- mobile phone use while riding
- riding without a helmet
- riding without lights.

"My main point," he stressed, "is that cyclists of all types and levels can do more to be safer on the road. As vulnerable road users we should take more responsibility for modelling safer on-road and in-traffic riding behaviour.

"Sure, there is room for improvement in driver attitudes and behaviours too. But ultimately cyclists can do little to control what drivers do. What we can control are the decisions we make, and the behaviour we display each and every time we ride.

"Focusing our efforts and energy on the things we do as road-users is a more positive and proactive approach than merely pointing the finger at problems caused by a minority of drivers.

"It is also likely to be a quicker pathway to earning respect as legitimate road users, and making a real difference towards improved cycling safety."

View from the saddle

Long-time cyclist and GPSpeak clinical editor, *Andrew Binns* shares his thoughts about pedal-pushing in the Northern Rivers…

It hardly needs saying that I would not have been a recreational and commuter cyclist for about 60 years without some enthusiasm for this activity. Cyclists will weigh up the benefits versus the risks as the number of reported serious cycle accidents seem to be on the increase including in our own region.

We live in times when bicycle imports have exceeded car sales for over a decade. Import figures across Australia have shown the growth in adults cycling and bike sales. Imports for adult bikes have increased by 21 per cent since 2009-10, whilst children's bike imports have recorded a 7 per cent fall over the same period. Some 30 per cent of all car trips are 5km or less, a distance that can be easily cycled.

- In NSW in 1971, only 12 per cent of children were driven to school, but by 2010 half of all secondary students were being driven to school (Bicycle Industries Australia, July 2013). According to a Royal Society for the Prevention of Accident Report (August 2014):
- Around 75 per cent of fatal or serious cyclist accidents occur in urban areas
- Around half of cyclist fatalities occur on rural roads
- 75 per cent happen at, or near, a road junction
- 80 per cent occur in daylight
- 80 per cent of cyclist casualties are male
- Almost one-quarter of the cyclists killed or injured are children
- Around three-quarters of cyclists killed have major head injuries.

To look at some of the hazards and some preventative measures, we need to look at all aspects of cycling.

Our Bikes

With the modeling for making bikes lighter being driven largely by the huge bike racing industry, material such as carbon fibre has been used. Whether these bikes are stronger than aluminum or other metal frames is open to debate, and in the accompanying article Max Osborne

(cont on p9)

Pedal Pushing (cont from p 8)

discusses this further .

Collapse of a bike frame or wheel whilst riding is a potentially catastrophic event, as Dr Chris Gavaghan recounts in his article.

Aside from weight, bikes are certainly more efficient, as the technology used with gears and brakes has improved so much. Other safety features such as vastly improved lighting back and front using light emitting diode (LED) technology has made riding at dawn, dusk and at night both feasible and safer.

A new craze of riding motorised bikes is gaining momentum. In my area I see young children and adolescents roaring around the streets on these bikes, often without a helmet and no need for a licence. This is highly dangerous.

Our clothing

If I can emphasise one safety feature for cyclists it is the need to wear bright clothing. Dark colours should be avoided and the choice is immense. However, bright clothing and lights doesn't mean cyclists are visible in thick fog, and this weather condition is reason enough to abandon a ride altogether.

Our riders

Just as there are good and bad drivers the same applies to cyclists. Skill, care, manners, knowledge of road rules and bike group-ride etiquette are all needed for safe cycling.

Our roads

Having been on a number of cycling trips to Japan, where the roads are smooth and well maintained, makes one realise just how bad our roads are and this can impact on safe riding. Pot holes are dangerous for cycling particularly those that seem to emerge on a steep descent. After a wet season they are particularly dangerous for cyclists. Wet roads can be slippery and riding to conditions is important.

Motorists

Again, motorists in Japan are very respectful of cyclists and the road laws and penalties favour the bike rider, which helps with safe riding. France is another country where cycling is such a significant sport that cyclists are treated with respect. Over there, a car approaching from behind on a narrow road will give a light toot of the horn to alert the rider of their presence rather than the kind of aggressive blast we often experience here.

That leads to the topic of road rage and the 'shave' given to some cyclists on their journey by a passing vehicle. The law says the passing width of such a vehicle should be one metre.

Wild life

One of the pleasures of cycling is being able to enjoy the environment. As well as the scenery there is the wild life one comes across. I have seen koalas, kangaroos, carpet snakes, wedge tail eagles, platypus in the creeks, and more in our wonderful area (whilst keeping my eyes on the road, of course!).

However, animals can also cause accidents when they unexpectedly stray out onto the road, particularly on steep descents. Then there are the magpies during their breeding season – they can literally bring a rider down when they attack from the side. Stray cattle and dogs can also propose a major hazard for cyclists.

I am delighted to report that cycling is becoming more popular, and in all likelihood this trend will continue in both urban and rural areas. With the push to encourage cycling for health, transport and environmental reasons, safety also needs to be addressed more seriously, with safer cycle ways and education for riders and motorists of all ages.

COMMENT

Up to government to do more

All three tiers of government speak of their commitment to

(cont on p10)

Pedal Pushing (cont from p9)

fostering a healthier community, and indeed many measures have paid great dividends. Think breast screening, quit smoking measures, immunisation, and more.

However, in regional areas such as the Northern Rivers there is relatively little encouragement for the healthy pursuit of cycling and the provision of safer cycle ways, especially in comparison to the many millions being spent on roads (much of it for the benefit of people passing through the area, not living here).

Lismore City Council told GPSpeak that its local government area has around 14km of dedicated cycleway, a tiny proportion of the road network. In 2011 it adopted a Cycleway Plan (Provide link to document) with $1.8 million having been spent since then, initially funded fully by the NSW Government when cycleways were adjacent to state roads, and matching funding 50/50 for cycleways on local roads.

In the 2013/14 financial year the state government changed its policy, and now provides 50/50 funding for all road-proximate cycleways.

The reduction has produced a significant drop in construction. In the 2013/14 year a mere 450m of cycleway were built in Lismore, at a cost of $200,000.

Lismore Mayor *Jenny Dowell* provided GPSpeak with the following comment –

"The reduced funding will result in Council's Cycleway Plan stalling in its implementation".

"Once upon a time everyone thought Lismore was far too hilly for cyclists and only children on bikes were catered for in local parks such as Wade Park. In recent years, however, many of our adult residents have taken up cycling as a leisure activity. It's now not uncommon to find groups of cyclists on our rural roads any day of the week or to come across them at our local cafes getting a caffeine hit before the ride home.

Steadily, but not as fast as some would like, Council has been implementing our Cycleway Plan of widening existing footpaths to cater for cyclists and building new cycleways, including some on the road.

The Plan gives priority to travel on major routes between 'attractors' such as schools, shopping precincts, sporting grounds and other well-used precincts. Council has taken advantage of full State government funding for cycleways on state roads, and 50:50 funding for our local roads, to implement more of the Plan each year.

Unfortunately the state government has now significantly reduced its funding. The 100 per cent funding for cycleways on State roads is now 50:50 and there is no funding available for cycleways on local roads. The reduced funding will result in Council's Cycleway Plan stalling in its implementation.

Today, cycling in Lismore is largely for fitness and leisure but if funding is reinstated to improve infrastructure and join up existing cycleways to provide a better network, as workplaces provide bike storage, lockers and showers and as motorists learn to share the road and be respectful of cyclists, I can see the day where cycling to and from work in Lismore is no longer a rarity."

A cracking good material

Because of its strength and light weight, Carbon Fibre technology has taken hold of the cycling world, but it does have a downside, as *Max Osborne* explains.

Most of us know the meaning of 'carbon' and 'fibre', but when they're brought together in a manufacturing process the combination holds unprecedented benefits for products as diverse as the aircraft in our skies and the bicycles on our roads.

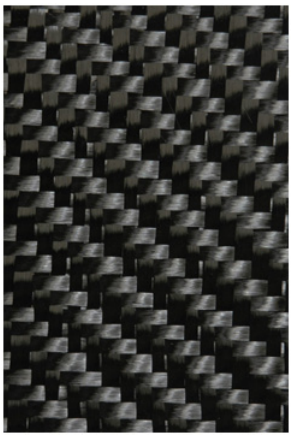
(cont on p11)

Pedal Pushing (cont from p 10)

So what is this seemingly magical product?

Carbon fibre reinforced plastic (CFRP) consists of thousands of individual strands of raw carbon filaments that are bundled together and typically woven into a fabric that is coated in a resin or 'plastic'. A stack of multiple fabric layers are then cured at high temperature and pressure in a process which compacts the fibres and hardens the resin to develop a stiff and strong composite material.

The structural properties are mostly provided by the carbon fibres themselves, with the plastic matrix serving to stabilize the material and hold the desired final shape.



Close-up of a woven carbon fibre fabric

Why Carbon?

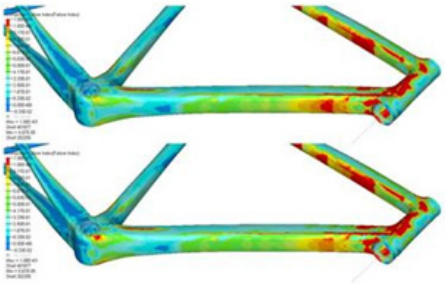
In a nutshell, the benefits of Carbon Fibre as a material for bikes over traditional metallic materials such as aluminum, steel or even titanium is that it is generally lower weight, more able to be tailored for stiffness and other frame characteristics, and less susceptible to corrosion and fatigue.

The design of the carbon fibre laminate allows the structural properties to be better customized than a metallic material where properties are generally the same in all directions.

During manufacture the plies of carbon fibre are stacked on top of each other to form a laminate, and it is the thickness and orientation of those plies that define the properties such as stiffness and strength.

Through specific design of the layup, engineers may locally increase stiffness in areas such as the bottom bracket and similarly save weight in regions where loads are lower, or reduce the stiffness to improve the ride comfort of the frame.

Another benefit of carbon fibre as a frame material is improved resistance to fatigue cracking from repeated application of loads throughout its lifetime. Whereas metal can (and eventually, will) develop cracks when cycled (no pun intended) at comparatively low levels of applied stress, the fatigue life of carbon fibre is essentially infinite because it need to be cycled in extremely high loads to suffer the same type of fatigue cracking.



Computer analysis of stresses in a carbon fibre composite bike frame – image courtesy *Cervelo*

In addition to the weight savings this is one of the reasons that carbon fibre is used in modern airplanes - it doesn't fatigue and develop cracks, and therefore needs less maintenance.

Drawbacks

While there are significant benefits of carbon as a frame material, there are also some drawbacks. Apart from higher costs to manufacture (although these are steadily going down) the main compromise is comparatively poorer damage tolerance and lower impact resistance when compared with metal.

When carbon fibre suffers an impact, the layers of carbon fibre can debond from each other. If no longer tightly compacted in a plastic matrix then the strength is significantly reduced and it may subsequently fail at much lower loads.

Metal is ductile and so a metallic bike frame with some local damage can redistribute load around the damage site through local yielding and plastic deformation, whereas carbon is brittle and has little or no yield behavior, so tends to fracture somewhat catastrophically.

Frame designers usually account for some levels of likely accidental damage

(cont on p12)

Pedal Pushing (cont from p11)

which may occur in areas such as the top tube by adding additional plies, however impact resistance is inherently one of the poorer structural properties of carbon fibre and if a frame suffers a crash it should be professionally inspected as sub-surface damage to the carbon layers may be completely invisible.

Usually carbon fibre failure will occur at the site of pre-existing damage and so while it may appear 'spontaneous' it is actually occurring at an already damaged location. Many bike shops and manufacturers will recommend that a carbon bike frame that has been in a crash be completely replaced (a similar warning applies when purchasing a second hand carbon bike – buyer beware!)

The author leads the bunch into the final corner of a Melbourne criterium race.

In the last five years carbon has essentially become the standard material for performance road bikes and is gaining traction for consumer bike components such as front forks and even lighter weight mountain bikes, although it is the lower impact resistance discussed above that somewhat limits its practicality for these applications.

**** Max Osborne is a regular cyclist, amateur club racer and carbon fibre enthusiast.***

View from the master

The reasons for cycling vary as much as the chosen financial outlay on the equipment to pursue it, according to one who knows the game from the inside, Darryl Pursey, proprietor of Lismore-based Harris Cycle Co.

Darryl Pursey, proprietor of Lismore-based Harris Cycle Company

A long-time cyclist himself, Darryl said that "acceptable entry level bikes" start at around $400, while the marked trend is for the high-end, carbon fibre bikes whose weight is as minimal as the cost is hefty, ranging from $3000-$3500.

It might be noted that both ends of the spectrum are 'Made in China'. Those wanting bikes from Europe or the USA should make sure their credit cards are well primed.

Established in 1918 and still going strong, the shop is a cycling cornucopia. According to Darryl the quality of bikes, like computers, as he put it, has continued to improve over the years.

In a reference to the rumoured fragility of carbon fibre, he said that, "Even in my day, steel frames broke, so there's nothing new about that."

As with other products - again, computers is a good comparison - fashion has an influence on demand. Carbon fibre frames are all the go these days, assuming you can afford them. Their lower weight is equated with a less demanding ride, and the branding might just help too. But there are potential pitfalls – see the adjacent articles.

In regard to safety, Darryl said, "I feel more secure here than on a shared cycleway in the city," explaining that with less distractions he can keep a sharper eye out for other riders and potential hazards.

While he's had the occasional stack, he has never broken a bone, but feels that for those who cycle-commute, an accident may be "only a matter of time", and the same applies to those who ride on highways.

Asked for tips, he advocated appropriate equipment, both bike and clothes, and proper lights. Darryl suggests group cycling, the reason being that a pod is more likely to be visible to other traffic, and consequently "respected".

The law decrees that cyclists can ride two abreast, although on our country roads, discretion is the better part of valour, and riding single file, or moving (cautiously) onto the verge is advisable if cars need to pass.

Darryl calls this "two-way etiquette", although common sense may be another way of putting it.

Timing is another key factor: he advises not riding in peak hour. Moreover, Darryl never rides in the Lismore CBD, or other centres, because people are simply not cycle savvy.

Let's hope this good advice from a master influences more people - cyclists and drivers – to take heed, and that fewer of the former end up in an emergency department, and fewer of the latter face the anguish that follows a collision with a cyclist that might well have been avoided.

Photos of Harold Wotherspoon and Cecil Harris, the original proprietors, take pride of place in Harris Cycles of Lismore, opened in 1918. Current owner, Darryl Pursey has worked in the shop since 1985, and bought the business six years later. He believes it may be the oldest bike shop in Australia operating from its original premises.

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

Being the patient, instead of the doctor

by Dr Chris Gavaghan
Emergency Physician, Lismore Base Hospital

Spring of 2012 had been a fairly dry season on the East coast, punctuated with a significant amount of windy days. Such was the 12th of October when I deliberated about how to get to work – drive my car or bicycle?

Like many Emergency Physicians, I find myself relatively time poor and find it a challenge to get sufficient, regular exercise. I have always found it appealing to use the opportunity of bicycle commuting a useful way to achieve both transport and exercise aims.

Despite significant winds (almost always a headwind), I stirred myself to cycle to work on that day. Geared up and on the way, I was soon glad of the choice to get some exercise until the very last kilometre of the journey when something totally unexpected happened.

I was riding a carbon fibre road bicycle, which suffered a structural failure and collapsed without any warning while I was travelling at approximately 40 km/h.

Suffice to say, I had an accident and was thrown over the handlebars, knocking my head and face on the ground, smashing my helmet apart and axially loading my spine. I woke in the coma position on the roadway.

Concussion was a novel and rather unusual phenomenon to be on the receiving end of.

Fortunately, the injury occurred only 1 km from the hospital so a rapid response of first aiders and ambulance occurred. When I regained consciousness by the roadside, the first thing I did was to go through a personal physical checklist. First was brain function, which I took to be satisfactory as I realised something seriously bad had happened. Second was a quick test of sensation and motor function to upper and lower limbs, similarly reassuring. Not so reassuring was the irregular feeling of my teeth and palate after some tongue probing or the awareness of spine pain.

Time seemed to take on a different dimension after the realisation of a trauma, which was significant, and the administration of a number of different analgesics

However, it is a daunting feeling being wheeled into the trauma bay of one's own department that had already been experiencing a very busy trauma day.

Familiar faces looked down on me on the ambulance trolley, somewhat unnerved to see one of their own staff as the patient.

It may have been the totality of the experience or the pharmacological assistance, but what struck me most was the feature of teamwork in action. Many different parties were involved in my assessment and care. Suffice to say, the staff were somewhat on edge knowing that I was one of their colleagues. I had a complete primary survey and detailed secondary survey in what seemed like minutes with the majority of major injuries flagged. A tertiary survey of mainly radiology (CT panscan) revealed the remaining relevant injuries. My recollection of this was patchy apart from 'we are going to give you a little injection of contrast – you may feel a warm flush' being a significant understatement. There were a number of humorous moments despite this.

One of my attending FACEM colleagues, who had been having a particularly busy day, was thinking out loud who was going to take over from her shift and on looking

(cont on p16)

On being the patient... (cont from p15)

down at me had the awful realisation of who that person should have been.

Another was of experiencing some of the many and varied pharmaceuticals that we so commonly administer to patients without ever having a first-hand experience of and some of the verbal concatenations that ensue.

Many deliberations ensued about my care between different teams and other specialised hospital units, but in the end, I was admitted to my own hospital (well and truly exceeding the 4-h rule). I was primarily under the general surgeons' care but shared with facio-maxillary and orthopaedics teams.

A week passed with a single facial operation needed before I was able to be discharged and commence the long road to recovery. The list of injuries to keep me company included concussion, Le Fort 1 fracture with pneumocranium, cervical spinous process fracture and two thoracic vertebral crush fractures along with sundry skin wounds.

Crossing over the line from doctor to patient is a significant step to take, especially when it is unheralded and occurs in your own work environment. It was certainly heartening to observe at first hand that many of the teachings we strive for in emergency medicine were applied, not the least of which was effective teamwork.

In many ways, it was one of the most overwhelming events of my life so far, especially when one contemplates the 'what ifs'. Equally overwhelming was the enormous expressions of support from work colleagues and friends.

Many personal lessons have been learnt as a result of this. We do so often deal with trauma patients who have had concussion and head injury, but in many of our work places, the resources to ensure comprehensive follow up of these patients is limited to say the least.

My own journey has been extremely eye opening but reassuring on one level, to think that the contemporary practice of Emergency Medicine most definitely has impacted on the delivery of acute care in a favourable way.

Accidental death of an early cyclist

On the global stage, the year of 1911 was marked by the overthrow of the Manchu dynasty, Orville Wright's world record glider flight, and Hiram Bingham's rediscovery of Machu Picchu.

LAUNCESTON.

CYCLIST'S SAD DEATH.

LAUNCESTON, Wednesday.—An inquest was held at the General Hospital to-day concerning the death of William Harper, who, while cycling between Derby and Moorina, collided with a cart. The deceased before his death admitted that he was riding on the wrong side, and making an effort to cross, when the bicycle swerved and he struck the horse. After the accident the deceased, who said he was not injured, returned to Derby. He became ill, and on admission to the Launceston Hospital it was found that his bowels had been perforated.

The coroner returned a verdict of accidental death, no blame being attachable to anyone.

Less noteworthy, although it rated a mention in the local press, was the death of cyclist William Harper who collided with a cart whilst, as he admitted, riding on the wrong side of the road.

Clearly he needed to be alive to make this statement. Indeed, he declared he was uninjured and returned home to Derby. Becoming ill, with a perforated bowel as it happened, he was admitted to Launceston Hospital and passed away on 6 May.

Mr Harper was one of the first, but by no means last, of the cycling fatalities and serious injuries in Australia since the bicycle became an integral part of our culture.

Hopefully, today's cyclists are more inclined to ride in accordance with the road rules.

Meet our ultra-marathon medico

Northern Rivers GP Charlie Hew sits down to discuss the 'world's greatest long distance race' with GPSpeak's Robin Osborne.

Most people would be delighted to have run 90 km in just over 12 hours, but it's the 'just over' part that disappoints local GP Charlie Hew who would possess a medallion marking the completion of the **Comrades Ultra-Marathon in South Africa** had he been a mere eight minutes faster.

At least he had the satisfaction of breasting the finishing line, for until recent times any runner still on the course after twelve hours faced locked gates at the stadium. This year's winner, it might be noted, completed the course in just five-and-a-half hours.

Dr Hew is not complaining, however, as the South African weather in June was unseasonably hot and humid: "I didn't train enough in the heat," he says over a bottle of water and a chai latte in a Lismore café, having just finished a morning 20 km run.

Moreover, he had never run 90 km before – his longest training run, he says, was 56 km, which just happens to match his age.

Dr Hew took up running seriously about five years ago, giving up cycling because of safety fears (see our special feature on Northern Rivers cycling). In the process he has inspired his four adult children and his wife, Kim Kerr, a fellow GP, all of whom now run. He is now a seasoned marathoner who looks forward to his next 42.2 km outing – the Melbourne Marathon in October - and his weekend pavement pounding with the active men and women of the Lismore Runners.

Despite club members' enthusiasm for pulling on the joggers, none could be persuaded to go along for the run from Pietermaritzburg to the coastal city of Durban, so Drs Hew and Kerr (the latter observing, not competing) headed off for an event that began in 1921 and today is billed as "a South African institution, internationally recognised for the body-sapping challenge it poses and the camaraderie it fosters among its thousands of participants".

"True enough," Charlie Hew says, adding that while he came within a whisker of beating the 12-hour limit he did achieve two of his three identified goals, getting to the start line and making every one of the depots along the way, albeit by only 15 minutes in the case of the last one.

It should be noted that he maintained momentum throughout, even if his style at times resembled more of a Cliff Young-shuffle than the gait of an Olympian.

Around 16,000 runners competed, 60 of them Australians whose mentor was a Brisbane enthusiast named 'Digger', now in his sixties, who has completed 15 Comrades.

Would Dr Hew consider a re-run in the hope of beating the 12-hour window?

"Certainly not," he responds, although the same answer applies to any suggestion of scaling back his running.

Melbourne is coming up, then there's the possibility of next year's North Face 100 (that's kms) in the NSW Blue Mountains and the Gold Coast Marathon, and of course a nice social run next weekend... and the following one, and the one after that.

Book Review

by Robin Osborne

The Golden Age

Joan London
Vintage Books $32.99

The scourge of polio, barely a memory these days, lies at the core of Joan London's latest novel, set in a children's convalescent home in Perth that ironically bears the name of the book's title.

The central character, 13-year-old Frank Gold, the son of wartime refugees from Hungary, has contracted polio and with other children been transferred here because their placement amongst adults at Royal Perth Hospital was deemed unsuitable.

It is 1954, a vaccine for polio is yet to be developed and many lives hang in the balance. The prospect of being crippled for life is considered a good outcome.

Despite the upbeat nursing staff, portrayed sympathetically, the facility is bleak, especially for those undergoing that most ghastly of management regimes, respiration in an 'iron lung'.

Visiting this ward, Frank meets another patient, Sullivan Backhouse, whose love of poetry will change his life. While not long for this world, Backhouse fuels a spark in his 'New Australian' friend and soon Frank is composing his own poetry on a leftover prescription pad.

Then Frank's heart captured by another patient, Elsa, and the juvenile romance progresses to an indiscreet if immature physicality that results in both being expelled from the Golden Age and returned in disgrace to their families.

Although briefly reunited, their lives diverge in later life, Frank becoming a writer, childless, living in New York, and Elsa a doctor and mother, in Australia.

Like London's previous works, this is a beautifully penned story, peopled by characters finely observed, not least Frank's immigrant parents, disillusioned by a 1950s Australia that provides them with freedom but little happiness. That is the reward for the next generation, despite Frank's childhood travails.

NCML considers its present and future

Over the last two months the North Coast Medicare Local (NCML) has held a series of meetings up and down the coast with its member organisations and local groups of GPs. The painful process of transitioning from Divisions of General Practice has largely consumed the energies of the NCML for the last two years and it is only now that a number of the programs relevant to general practice are coming on stream.

Options for improved support for After Hours Care, which has been a protracted and difficult issue for the NCML, were discussed at the joint NRGPN Board / NCML executive meeting on 10 July 2014. The Board has argued for continuing assistance in cold chain maintenance, sterilisation, IT support and other matters pertinent to passing GP accreditation.

The possibility of getting assistance in the calibration of practice equipment such as spirometers and BP machines was once again canvassed. GP Accreditation support has been maintained by the NCML through its Practice Assistance Liaison Officers scheme, although access to these officers has been reported to be variable from practice to practice.

Chewing the fat - NRGPN members David Sare, Brian Witt, Andrew Binns, Sue Page and David Guest are flanked by NCML executive members Vahid Saberi, Chris Clark and Tony Lembke at the Lismore breakfast meeting on 1 July 2014 discussing the future for both organisations

'D' Day 31 March

The Board also questioned the possibility of future support for the NRGPN's administrative functions when the current three-year agreement expires on 31 March 2015.

In the past six months the NRGPN Board has recognised the need for national, and in our case local, GP education in the insertion of long acting reversible contraceptives (LARCs). It is also of the opinion that the community-initiated "Last Drinks @ 12" campaign in Byron Bay to minimise the harm from alcohol fuelled sexual assault and violence be supported. Our interest in progressing these issues, as well as others of significance to North Coast GPs, was made clear to the NCML Executive.

Given the cloud over the future of primary care support itself, nearly all GP support issues remain uncertain. The Coalition government has followed the recommendations of **the Horvath review** and is closing all Medicare Locals on 30 June 2015. It will replace them with Primary Health Networks (PHNs). The size, scope and function of these new organisations has been the subject of much debate and their format will not be known until later this year at the earliest.

This will leave perilously little time for any new organisation to be operational come 1 July 2015. The NRGPN Board felt that once again there could be a tragic waste of time and resources in working through any new administrative arrangements.

All is not doom and gloom in primary health, however. The NCML Emergency Medicine training program for local practices has started across the region. This is being offered through the University Centre for North Coast. The recent workshop on Airway Emergencies in General Practice has been well received.

The Health Pathways Program that originated in Christchurch NZ several years ago has been adopted by a number of centres in Australia. It aims to give all members of the primary and secondary health sectors clear guidelines on how to manage a range of medical issues. The pathways are agreed amongst local clinicians and

(cont on p20)

NCML and the future (cont from p19)

guidelines are tailored to the constraints created by a lack of local resources. The NCML Health Pathways program started on the Mid North Coast last year and has now been extended to the Far North Coast.

The NCML / Northern NSW LHD Co-location project also started earlier this year and is making headway in options for jointly managing chronic disease patients in the future. To date several clinics have been conducted in local GP surgeries by expert LHD nurses experienced in heart, lung and renal disease.

In addition, the **NCML Kaizen program** has recommenced this month after a two-year hiatus. This program combines the kaizen philosophy of continuous improvement through local meetings, webinars and surgery visits. It first started on the North Coast eight years ago and has proven to be a highly effective tool in bringing about practice change.

Finally, there is the prospect of further Integrated Care Projects on the North Coast, given the interest of both State and Federal governments in developing more effective and efficient care. The good relationship and innovative spirit in both the primary and secondary health care sectors makes the North Coast an ideal location to trial these new approaches to patient focused care.

The NRGPN is keen to ensure the progress made by the NCML in the last six months can be sustained by the new organisation that will take over. This new PHN will need to have the same commitment to patient focused care and system improvement. We hope to be able to shout, “The King is dead, long live the King.”

Kaizen returns to the North Coast

After a two year hiatus the North Coast Medicare Local (NCML) Kaizen meetings resumed this week at the St Vincent's Hospital Education Centre in Lismore.

Chiron Weber, Practice Manager Mullumbimby Medical Centre

Kaizen is the Japanese word for "good change" and is the philosophy adopted by businesses in post war Japan to rapidly raise the quality and efficiency of manufacturing and service industries. It equates to the English word "improvement" and therefore not surprisingly is a key strategy of the Improvement Foundation's philosophy of "continuous improvement".

Chiron Weber, winner of the inaugural NCML PITCH award, described the continuous improvement methodology and emphasised one of the other concepts of the improvement process, "Sharing Generously and Stealing Shamelessly".

Donna Gibson spoke on the Alstonville Clinic's experience in implementing the Coordinated Veteran's Care program. She emphasised the value of motivational interviewing as described in the CVC Program's Module 2 (page 92) and youtube videos (Bill Matulich - An Introduction to Motivational Interviewing, Stephen Rollnick - Motivational Interviewing)

Dr David Guest of the Goonellabah Medical Centre outlined his clinic's progress with the DVA's telemonitoring project. He spoke of the difficulty in finding suitable patients for enrollment and early experiences with using the web interface. He noted that the acceptable ranges for parameters such as pulse rate and glucose levels needed to be adjusted for individual patients. He also noted that the system had already uncovered raised systolic blood pressure in one of his two patients and that treatment adjustments were being made.

Dr Tony Lembke, Chairman of the NCML, rounded out the evening with a discussion on the future of the NCML and of the Kaizen program. It was agreed that further meetings would be held monthly and that some meetings should be held in members' clinics. It was also agreed that the SVH Education Centre made a good home base and that at least some of the future meetings would be webinars linking with other kaizen groups across the North Coast. The Kaizen group at Healthy North Coast will support inter-meeting communication and collaboration. The next meeting of the group will be in late September at the Alstonville Clinic.

Exercise and heart disease

Coronary Heart Disease (CHD) is the leading cause of death in Australia and it is estimated that over 20% of CHD worldwide is due to lack of physical activity. Exercise is an effective tool in both the prevention and treatment CHD, with recent research indicating that exercise may be as effective as pharmacological agents in the secondary prevention of CHD.

Exercise provides a therapeutic effect via a number of mechanisms. These include its positive effect on myocardial oxygen demand, endothelial function, clotting factors and inflammatory markers. Exercise can also play an indirect role by influencing the risk factors for CHD including cholesterol levels, blood pressure, obesity and hyperglycaemia. In addition to this, exercise improves general physical functioning and psychological wellbeing.

The National Heart Foundation recommends patients with CHD do 30 minutes of moderate intensity physical activity on most if not all days. Moderate intensity means that exercise should cause a slight increase in breathing and heart rate and perhaps some sweating. For those who experience exertional angina, exercise intensity should be at a level where their heart rate stays at least 10bpm below the level at which they experience angina symptoms. Many individuals with CHD may also have reduced strength, therefore resistance exercise is beneficial in order to maintain function and improve wellbeing.

Barriers such as deconditioning, time and motivation may make it difficult to do a full 30 minute bout of exercise at a time. However this can be overcome by accumulating 30 minutes of exercise by doing short 10 minute bouts of activity. Incidental activity can also play a significant role in achieving exercise guidelines. Unfortunately many people don't know where to start when it comes to taking up regular physical activity. When they think of exercise they think of people slogging it out on reality TV show such as "the Biggest Loser" or they think of gyms full of beautiful fit people. For many individuals with CHD this can put them off exercise. But the reality is a quick 15 minute walk on a lunch break plus throwing the footy in the backyard with the kids, then doing some vigorous housework such as mowing or vacuuming are all legitimate ways of accumulating 30 minutes of physical activity.

Jasmin Ritchie, Embrace Exercise Physiology

An accredited exercise physiologist (AEP) can provide tailored assistance and education regarding appropriate exercise for an individual with CHD. AEP's are also trained in implementing strategies to help people take up regular exercise and stick with it in order to make the most of the therapeutic benefits of exercise.

Update on Hepatitis C

by Dr Mark Cornwell, Director of Lismore Liver Clinic

Clinical Nurse Consultant, Mark Fuller and Dr Mark Cornwell of the Lismore LIver Clinic with the new Fibroscan machine; Image and article all rights reserved by the author

PEG-interferon & ribavirin have been the mainstay of hepatitis C therapy for the last decade, with the addition in the last few years of the first direct-acting antiviral drugs (DAAs), telaprevir and boceprevir, for genotype 1 infections. These drug regimes have led to cure for many patients, but have been unsuccessful in many, and have been poorly tolerated. Many patients have been unwilling to have treatment due to fear of side effects.

A new era in interferon-free therapy is coming, with new DAAs showing great promise, with very high cure rates and minimal side effects in trials. New treatment regimes will typically be one daily dose, taken orally, for between 12 and 24 weeks, with even shorter regimes showing promise. The first drugs have been approved in various countries, and sofosbuvir and simeprevir are already in widespread use in the USA. The timing of availability of new drug regimes in Australia is unclear, with concerns that the high cost of these drugs will limit availability.

This uncertainty makes treatment decisions difficult, as undoubtedly the new DAA regimes will be more effective and much better tolerated than existing therapy. The duration of therapy will often be much shorter in the future. Interferon-free therapy appears likely to be successful in difficult-to-treat patients such as decompensated ... cirrhotics, post liver transplant, HIV co-infection and non-responders to previous therapy.

The current challenge is to identify patients who should be treated now. Our aim should be to treat those patients at most risk of adverse outcomes without treatment, and should aim to identify patients with advanced fibrosis or early cirrhosis.

The Lismore Liver Clinic now has a Fibroscan machine, which allows non-invasive assessment of liver stiffness, a reasonable proxy for fibrosis. The patient experience is similar to having an ultrasound. The results are generally reliable for high & low scores, with good prediction of high and low fibrosis scores. Intermediate results are less useful.

Other non-invasive tests are available. ARFI is another technique to measure liver stiffness, but uses a conventional ultrasound machine (only available in some radiology practices). Various panels of serum markers are available. SNP pathology now offers an enhanced liver fibrosis score (ELF), which is also reliable for high & low scores, with a significant intermediate range. All non-invasive tests attempt to assess liver fibrosis without the need for liver biopsy.

Patients who appear likely to have advanced fibrosis should be assessed for immediate treatment. All patients should be advised to modify lifestyle factors known to hasten fibrosis progression - avoid excessive alcohol consumption, daily cannabis use and obesity/ metabolic syndrome.

Trials reported at EASL 2014 showing excellent results, with associated pharmaceutical company:

- ***Gilead: Genotype 1-6 for sofosbuvir and GS-5816, ledipasvir mainly active against G1***
- ***AbbVie: 3D (ABT-450/r/ABT-267 + ABT-333): G1 and G4, plus ribavirin***
- ***Merck/MSD: MK-5172, MK-8742 G1 with ribavirin***
- ***BMS: dalcatasvir, asunaprevir and BMS-791325 G1-4***
- ***Janssen: simeprevir – G1, used with PEG-INF, ribavirin and Gilead's sofosbuvir***

Eat more omega-3 to reduce heart disease risk

Omega-3 fatty acids are a vital part of every cell-membrane in our body. Eicosanoids derived from Omega-3 have potent anti-inflammatory properties preventing atherosclerosis. In addition Omega-3s play a role in cancer prevention, brain development and function, vision, preventing depression, reducing pain, reducing body fat and insulin resistance.

Cardiovascular benefits of Omega-3s include: promoting vasodilation; reducing platelet aggregation, blood viscosity, blood pressure and resting pulse rate; increasing arterial compliance and ventricular filling capacity; raised HDL levels and reduced triglycerides.

To reduce the risk of heart disease the Australian Heart Foundation recommends increasing Omega-3 intake as its second Nutrition Goal within their guidelines for the management of patients with existing coronary heart disease (CHD). Nutrition Goal number two states that patients with established CHD should consume 1 g eicosapentaenoic acid (EPA) + docosahexaenoic acid (DHA) and > 2 g alpha linolenic acid (ALA) daily.

Short chain Omega-3's (ALA) are essential fatty acids which our body cannot produce and must be consumed in our diet. ALA can be converted to long chain Omega-3's (EPA and DHA) in our body. However, EPA and DHA are now also considered to be essential dietary fatty acids due to their significant health benefits.

While the health benefits of dietary Omega-3 seem clear, how to achieve the Heart Foundation's recommended intake may be less obvious. So which foods provide which Omega-3's?

Dietary sources of long chain Omega-3, known as marine Omega-3 (EPA and DHA) are found in seafood, particularly oily fish such as salmon, sardines, mackerel, mullet, blue mussel, calamari, oysters, herring, blue eyed cod and gemfish, as well as omega-3 enriched eggs, and of course fish oil supplements.

For prevention of CHD, 500mg EPA + DHA is recommended per day, which equates to eating some form of seafood or 2 large omega-3 enriched eggs everyday (for example, a tuna salad sandwich at lunch or 2 poached eggs for breakfast).

For existing CHD, 1000mg EPA + DHA is recommended, which equates to eating 150g serve of seafood (especially oily fish) and 2 large omega-3 enriched eggs everyday (for example, 2 poached eggs for breakfast and salad with salmon at lunch).

Plant foods rich in short chain Omega-3 (ALA)include walnuts, flaxseed/linseed oil or ground linseed, Chia seed, soybean and canola oil and margarines, tofu, and microalgae.

To consume 2g of plant Omega-3s (ALA) per day, cook with a small amount of canola oil AND use a thin spread of canola or soybean margarine on 2 slices of soy and linseed bread each day, OR alternatively, add 2 tsp Chia seed or ground linseed/ flaxseed to muesli or a smoothie for breakfast and include about 5 walnut halves in morning or afternoon snack.

Adelle Purbrick blogs at her website *bodybalancenutrition.com.au*

Nutrition Tip: store ground flaxseed/linseed in the fridge or freezer to prevent oxidation of fatty acids.

In addition to increasing Omega-3 intake, the Australian Heart Foundation nutrition guidelines also recommend the following to reduce CHD risk: replace saturated and trans fats with monounsaturated and poly-unsaturated fats, and reduce salt intake.

An accredited dietitian can provide individualised dietary advice to further reduce CHD risk in your patients.

The doctor will see you *all* now.

Shared Medical Appointments: the coming medical consultation

Shared Medical Appointments (SMAs), where doctors see patients in groups of 6-12 over a one hour period, are set to become the next big thing in chronic disease management, with the first Australian trials now being completed on the NSW North Coast.

SMAs (also called 'group visits') have been defined as: "A series of individual medical visits carried out sequentially in a supportive group setting where all can listen, interact and learn." They have been used in the US for over a decade, but haven't taken off in Australia because of the belief that they don't qualify for medical benefits.

However, discussions with Medicare and a submission to the Medical Services Advisory Commission for a special item number through the Australian Lifestyle Medicine Association (ALMA), has opened up the process for consideration.

SMAs offer the advantages of more time with the doctor; peer support from fellow sufferers and input from other allied health professionals. Patients claim they learn more, don't have to remember all the questions they usually forget (because others ask them for them), and actually enjoy the process better than their usual care.

SMA - Bourke, NSW May 2014

SMAs have particular appeal as a better way of managing the ~70% of medical consultations that are now due to chronic diseases. These require longer term management and more care than the infectious diseases of the past.

Interestingly, doctors claim to also enjoy the SMA as a break from the routine of advising dietary, exercise, stress management changes etc, that underpin most chronic diseases and hence have to be repeated ad nauseum.

SMAs require at minimum, a doctor, and a trained Facilitator. However other experts can be invited to join the team as an option if desired. It also is possible to have observers – possibly enhancing the student experience .

As the key person, the Facilitator is responsible for organizing the group, keeping medical records, moving the doctor through individual consults and generally keeping the show on the road for an hour to an hour-and-a-half. Because the Facilitator or other documenter records medical notes it also means the doctor can focus more on the business of doctoring.

The Facilitator (usually a trained practice nurse or allied health professional) can also contribute to the consult, particularly where he or she has a specialty area. Groups can be homogenous (eg. all diabetes, heart problems etc), or heterogeneous (eg, any chronic disease).

The big question has been, 'would SMAs work in Australia?'

As part of an RACGP grant, ALMA together with the Baker International Diabetes Institute (IDI) in Melbourne are currently completing a test of this on the north Coast and western NSW. After around 20 groups with almost 150 patient visits, all the signs are positive.

As with published US data, there is almost 100% acceptance of the process with patients and providers involved in the trials. Earlier work suggests that this lev-

(cont on p26)

Kevin Hogan
MP for Page

Order in the House

Those in the medical profession would be well aware of Motor Neurone Disease, but until recently many in the broader community who have not been touched by this debilitating condition would not have been aware of it.

The international social media phenomena of the Ice Bucket Challenge has changed all that, and after knowing a few people in Page who have lost their battle with MND, I gladly endured momentary discomfort and accepted the challenge to help raise that awareness.

So far the challenge has raised about $US80 million worldwide. If you wish to donate go to **www.mndaust.asn.au/Get-involved/Ice-Bucket-Challenge**

Since my last column, Parliament has been on winter recess which has allowed me to spend all of my time in Page rather than in Canberra.

I represented the Federal Health Minister Peter Dutton at the opening of the new Women's Care Unit at Lismore Base Hospital. It is part of the new Stage 3A redevelopment of the hospital.

My wife gave birth at the old unit, so I know about the lack of privacy and the very cramped conditions – something that a mother-to-be should not have to endure.

The new 10-bed unit has private rooms and had already seen 238 birth since it was unofficially opened in June.

During the recess I have also caught up with many community groups to help them promote the terrific and vital work they do.

Kevin Hogan takes the Ice Bucket Challenge

This included meeting with the likes of Cranes Community Services in Grafton and St Andrews in Ballina to discuss their Care Respite Programmes.

All too often, when people are sick we focus on them and their needs – as we should – but we must never forget to care about the carers. These people provide the necessary non-medical care to help their loved ones back to health.

I also caught up with Grafton's New School of Arts – Neighbourhood Inc to discuss the planned expansion of its Community Visitors Scheme made possible by a $31,000 Federal Government grant.

Programmes like this and the Broadband for Seniors Kiosks, which I also announced over the last few weeks, helps to break down the social isolation felt by many of the most vulnerable older members of our community and keeps them mentally alert and healthy.

Shared Medical Appointments (cont from p 25)

el of satisfaction jumps from around 75% once the process is tried.

Confidentiality is no problem, because attendees are asked to sign a confidentiality agreement before attending a group. In thousands of SMAs in the US and Europe however, not one case of breach of confidentiality has been noted.

Up-skilling is required for nurses and others to act as Facilitators, and to this end ALMA is planning the first of a series of one-day training programs on the Gold Coast in November (see promotion this page).

Of course if the answer is 'no' to the question 'do you want extra people with that' when patients book a medical consultation , they can always go back to the single consult system that has operated since the days of the tribal medicine man.

It's likely however that Gen Z will see group medical visits as just part of the medical furniture of the future.

Preparing to face up to patients

Medical students from the University of Wollongong and the University of Western Sydney were face-painted with local ochre during their Aboriginal cultural awareness program at Cape Byron.

In a placement program coordinated by the University Centre for Rural Health (UCRH), a total of 40 senior medical students from the University of Wollongong and the University of Western Sydney begin the 12-months practical component of their training program in mid-July.

Medical students (l-r) Kate Sandy, Thomas Pearson, Sarah Kong and Matthew Knox

The students will undertake a rotation of supervised placements at local hospitals, including Lismore Base Hospital, Grafton Base Hospital and Murwillumbah District Hospital, other local hospitals, Aboriginal Medical Services, and GP practices. 26 of the students (18 from UWS, 8 from UOW) started in Lismore, 9 UOW students in Murwillumbah, and 5 UOW students in Grafton.

Local orientation for the students will include social and cultural activities.

"The students in the new cohorts have already completed two years of university study in medicine and are now embarking on the next important stage of their careers, the mandated practical placements," said Dr Michael Douglas, UCRH Director of Education.

The UCRH has educational campuses in Lismore, Murwillumbah and Grafton. It coordinates long-stay placements for medical and allied health students from The University of Sydney, University of Wollongong and the University of Western Sydney, as well as students from many other universities across a range of disciplines.

"These students, and others who will come throughout the year, choose the Northern Rivers because of the reputation of local health facilities and of the many skilled clinicians who generously share their knowledge and 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 helping them to hone their skills as well as making an investment in the regional health care capacity of the Northern Rivers and Australia more generally."

"Supervised experience of this kind is an essential part of becoming a qualified doctor, but it's much more than that," Dr Douglas said.

"We bring to the students a broad understanding of their role as a professional, and as an advocate, with a 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.

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:

Medfin focuses exclusively on the financial needs of medical, dental and healthcare practitioners. With more than 20 years of market experience, Medfin is an Australian leader in finance for healthcare professionals.

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

CONTACT :Therese Pearce EMAIL: Therese_Pearce@medfin.com.au MOBILE: 0418 168 426