GPSpeak

Matchstick man is a ‘clever fella’

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GPSpeak

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Matchstick man reflects Bundjalung culture

Every dot in 'Clever Fella', the extraordinary artwork on the cover of this issue of GP Speak, was done using a matchstick. Not surprisingly, it took the artist six months to complete.

Lismore-born Adrian ('Cheesy') Cameron is a Bundjalung man in his late 40s. This work was done on commission for a local medical practitioner who admires Adrian's work, other examples of which have been exhibited in the Northern Rivers over recent years.

We thank Adrian for giving permission to mention that his life has included considerable hardship and significant health issues. His obvious talent shines through, showing that painting is not only therapeutic, but stretches his creative instincts and helps keep the Bundjalung nation's culture alive.

Acknowledgement

The artwork on the 'Koori Country' graphic in this edition of GP Speak is a section of the painting 'Mulla Jullums on Journey' by Adrian Cameron. We thank the artist for his permission to use the image.

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Editorial

In Australia, life expectancy has increased by almost 25 years over the last century, and continues to rise at the rate of three months every year. Alas, this marked improvement has not extended to the Indigenous community.

This issue of GPSpeak reports on the parlous state of Aboriginal health and explores some ideas for narrowing what is somewhat euphemistically termed "the gap". The solutions are unlikely to entail more medication, acquiring more information or allocating resources, except in the most targeted way. Nor will it depend on greater compliance with medical advice.

The way forward requires a more consultative approach. The traditional didactic format of doctor informing patient of the diagnosis and management regime has been found to fail in Indigenous health. It also fails in community public health discussions, chronic disease management and cancer care. Nobody likes being preached to, particularly in what may become a life or death decision.

Many people come to major decisions by learning about their options, talking with family and friends, and mulling on things for a while.

Dr Andrew Binns, along with A/Prof Garry Egger and A/Prof John Stevens, are pioneering shared medical appointments, including Indigenous sessions, on the North Coast. Having a 'yarn' with peers over common troubles has more impact than the presentation of research data, guidelines and flow charts. The impact of chronic lung disease or renal dialysis on a patient's family and community is rarely caught in scientific papers. Facts may inform us but attitudes and beliefs move us.

It remains crucial that group consultations are supported by trained health professionals. The medical options must be made available in a format suitable for the patient. Tools to help understand complex medical issues are becoming increasingly available through groups like Shared Decision Making andd Option Grids. However, resources may need tailoring to the Australian environment and cultural awareness training remains crucial for all health professionals working with Indigenous patients.

The shift to deprescribing in Australia may yet be followed by the trend to deinvestigating. It is far better to do the "right thing" than take lots of drugs and do lots of tests.

Lismore City Council should be congratulated on their national award for creating healthier communities with their Move2Change program.

GPSpeak has quoted Dr Robert Butler previously. "If exercise could be purchased in a pill, it would be the single most widely prescribed and beneficial medicine in the nation."

The Council should also be congratulated on including cycle safety in its new traffic plans. The benefits and risks of cycling was the subject of the previous issue of GPSpeak and remains for many of us a key issue both professionally and personally.

Local artist Adrian Cameron's wonderful cover image highlights how the "Clever fella" used his knowledge of plants for medicinal purposes... when the drugs don't work, other approaches may, particularly when 'taken' early.

Ballina gets new MRI service

A new Magnetic Resonance Imaging (MRI) unit has been installed at the Ballina branch of North Coast Radiology Group (NCRG) in Tamar Street.

The equipment, a state-of-the-art Siemens Aera 1.5T, complements a line-up of diagnostic imaging equipment enabling NCRG's experienced team, including accredited Radiologists, to deliver the most comprehensive range of diagnostic imaging services within the one Ballina location.

Features of the new MRI unit include a short, wide bore and quieter exams. This helps support more types of patients and improve patient satisfaction.

Delivery of the new MRI unit

The new unit is capable of handling the extensive range of MRI examinations that medical practitioners normally expect as well as delivering additional services such as dynamic prostate scans and non-contrast MR Angiography for patients with renal problems.

The new MRI service will commence 1 Dec 2014, with hours of operation being 8.30am to 4.30pm Monday to Friday. The new MRI scanner does not have a license for Medicare rebates (due to present Federal Government policy), consequently, under present legislation, MRI scans performed at Ballina cannot be bulk billed.

Bookings and appointments can be made through NCRG Ballina branch on 6618 2900.

Referrer Enquiries, please contact Helen Spurgeon.
hspurgeon@ncrad.com
- tel 6623 6131

Two-speed Indigenous health continues

Dr Andrew Binns
Clinical Editor

Comment

The latest Australian Institute of Health and Welfare (AIHW) report Mortality and life expectancy of Indigenous Australians 2008 to 2012 shows that estimated life expectancy at birth for males was 69.1 years and for females 73.7 years. These may sound like good figures – if we were living in the previous century. The sad fact is that they are 10.6 years and 9.5 years lower respectively than the life expectancy of non-Indigenous males and females.

While the report by the AIHW – which is the federal government's main data collection agency on health trends - did show small improvements in Indigenous life expectancy, the gains had done little to close the longevity gap because non-Indigenous life expectancy improved much more markedly in the decade to 2012. In some diseases, including cancer, the gap was actually widening": non-Indigenous Australians were found to be living longer, with Indigenous mortality rates rising.

One encouraging trend was a 57 per cent decline in the Indigenous infant mortality rate between 2001 and 2012 (with a 26 per cent decline in the non-Indigenous rate). Over that period, there was a significant decline in the mortality rate difference between Indigenous and non-Indigenous infants, with the gap, which still continues, more than halving.

These large declines in infant mortality in recent decades are likely to be the result of large reductions in deaths from sudden unexpected death in infancy (which includes SIDS), and deaths from conditions originating in the perinatal period (AIHW 2013).

"Indigenous diabetes rates are three times the rest of the population"

However the reason for the adult longevity gap is chronic disease, with four groups accounting for more than two-thirds of the problem: circulatory disease 24 per cent of the gap, endocrine, metabolic and nutritional disorders 21 per cent, cancer 12 per cene and respiratory diseases 12 per cent.

Between 2008 and 2012, cancer accounted for 20 per cent of all Indigenous deaths, with lung cancer, the most common cancer death, accounting for 5.1 per cent of deaths in Indigenous males and 4.7 per cent in females. Lung cancer rates rose slightly in the Indigenous population from 2001 to 2012.

A second report released by the Australian Bureau of Statistics showed one in 10 indigenous people had diabetes, which is three times the rate of the rest of the population.

It is well known that chronic diseases are largely lifestyle based, which in turn relates very much to social determinants such as the location where people live, inadequate housing, poverty, poor education, lack of job prospects, access to health services, transport issues, high incarceration rates, and so on.

Primary health care services are important but they are hamstrung by providers' inability to adequately address these social determinants, this being a socioeconomic and political issue.

Martin Laverty, the chief executive of the Royal Flying Doctor Service and the founder of the Social Determinants of Health Alliance, said too little had been done by governments to improve the living conditions of indigenous Australians. (SMH 10/09/14)

"Diabetes is a disease that is entirely preventable, but we don't yet have, as a nation, a sufficient commitment to recognising that where you live and your geography, influences your risk of chronic illness," he said.

He highlighted the broadly supported Senate report in March 2013 that had recommended five ways in which the government must act to address the social factors that cause ill-health, yet that report was "still sitting on a shelf awaiting a government response".

The Senate Report's List of recommendations -

Indigenous health gaps

(1) The committee recommends that the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian context.

(2) The committee recommends that the government adopt administrative practices that ensure consideration of the social determinants of health in all relevant policy development activities, particularly in relation to education, employment, housing, family and social security policy.

(3) The committee recommends that the government place responsibility for addressing social determinants of health within one agency, with a mandate to address issues across portfolios.

(4) The committee recommends that the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinants research.

(5) The committee recommends that annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.

For now we can only hope the Closing the Gap initiatives for general practice and Aboriginal Community Controlled Health Services continue to be supported and that the disadvantaged, including Indigenous people, are exempt from the Government's co-payment proposal for GP visits should this pass the Senate.

Additionally, measures like smoking cessation programs need to be stepped up, not wound down as appears to be the current fashion http://blogs.crikey.com.au/croakey/2014/08/25/indigenous-smoking-program-cuts-risk-widening-the-gap/?wpmp_switcher=mobile

In fact, the Australian government has recently announced funding cuts of $130 million over five years to the Tackling Indigenous Smoking program, which amounts to more than one-third of the program's annual funding.

If such an important initiative runs out of breath, so will the many people whose future well-being depends on being encouraged and supported to adopt healthier lifestyles.

'Yarning' a key component of consulting

In the article ("Two-speed Indigenous health continues") it is apparent that one of the greatest challenges to improving the gap in life expectancy between Indigenous and non-Indigenous Australians would be to find better ways of managing chronic disease. Despite the current effort and resources put into this, progress is painfully slow and in some areas of health, such as diabetes management, it is just not working for the majority of sufferers.

A better approach may be for Indigenous people to self-determine what they want to discuss during consultations, to hear about practical and affordable ideas for lifestyle change, and to address their health problems.

Whatever the lukewarm response at the federal level, health literacy is all-important and GPs in Aboriginal health services and mainstream practices are well placed to actively

Lismore SMA which was trialed in a garage under the Rekindling The Spirit building.

It is all very well, and appropriate in terms of duty of care, for practitioners to be advising Indigenous (and non-Indigenous) people to quit smoking, avoid junk food and soft drinks, consume less alcohol and exercise more. Unfortunately, and not surprisingly, this often falls on deaf ears.

This is often seen as just another patronising approach into how people with often limited financial resources and unsupportive environments should listen and tune in to what is achievable.

One-to-one consultations certainly have their place but there may be other ways as well. In the last GPSpeak, and again in this one, there was an article about Shared Medical Appointments (SMAs), where doctors see patients in groups of 6-12 over a one-hour period.

SMAs were said 'to become the next big thing in chronic disease management, with the first Australian trials now being completed on the NSW North Coast.'

SMA trials have now been done in Indigenous communities in Walgett, Bourke and Lismore. The Lismore SMA was conducted under the auspice of Rekindling the Spirit (RKS), an Indigenous support organisation that has been running regular support groups over many years.

To bring a GP into a group of 10-12 men was trialed in the garage under the RKS building. It could just as well have been held under the shade of a tree - all is needed is a basic meeting place for a 'yarn' lasting 90 minutes with a facilitator to organise and run the group session and a GP coming into the circle for 60 minutes.

NEWS CLIPS

Doctors battle Ebola

Since the beginning of the Ebola outbreak in West Africa, Médecins Sans Frontières (Doctors Without Borders) has admitted more than 4,500 patients to its care centres.

Among these, over 2,700 were confirmed as having Ebola. To date, 1,000 have survived the disease.

One survivor was the son of a health promotion officer with MSF, who wrote of losing all family members except his teenage boy.

He asked about his son's ambition after high school. "He told me that he wants to study biology and become a medical doctor. That's what he told me!"

MSF has 3,000 staff working in the region.
http://www.msf.org.au/

Health Alliance backs UCRH

The Northern Rivers-based University Centre for Rural Health (UCRH) is celebrating the appointment of a second member of its staff to the board of the National Rural Health Alliance (NRHA), Australia's peak non-government organisation for rural and remote health.

At its recent AGM the 37 organisations that make up the NRHA elected a new Executive for the coming twelve months. The Board Members now include UCRH Pharmacist Academic Lindy Swain who joins the UCRH Director, Professor Lesley Barclay AM, the Alliance's Deputy Chairperson.

"For us to have two people on the Board of such an active and high-level body is a real vote of confidence in the talent base here in the Northern Rivers." Pro Barclay said.

http://ruralhealth.org.au

Senate Submission

The Senate Select Committee on Health is currently holding Australia-wide hearings, with key criteria including Indigenous and rural health, better integration of Medicare-related services such as access to GPs and other care providers, and the implications of "reduced Commonwealth funding."

The Committee's terms of reference are detailed on the inquiry's home page

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health

Senators held a one-day session in Lismore on 15 September. Local GP Dr Jane Barker took the opportunity to present her submission...**Read more** at **http://nrgpn.org.au**

'Yarning' at SMAs

Each person has a chance to be heard and asks the GP for advice on a health topic of their choosing. There is plenty of opportunity for health education and for all to hear and engage in the group conversations. The group dynamics work very well in this environment, as evidenced by the positive feedback received.

If matters come up that require further one-toone consultation, arrangements are made for this. The facilitator's role is crucial to get the group engaged and focused on the health agenda of each participant and the GPs role is quite straightforward and enjoyable. A wide range of topics can be covered. The return SMA visit rate was very high over three sessions.

More SMAs are being planned for an Indigenous women's group. There is increasing interest from GPs to become involved. I have personally found the groups work well, with great patient feedback, and they are fun to do. Research is needed in the future to see if the proven patient satisfaction leads to better health outcomes through lifestyle changes and better treatment compliance. I am highly optimistic.

Resilience in Creativity

by Dr Andrew Binns

The 'clever fella', the subject of my painting, played an important part in Aboriginal culture for the Bundjalung people. He was a healer who could use his knowledge of plant life for medicinal purposes to heal people in the tribe. And he was known as the one who upheld the 'lore' if anyone in the tribe broke it.

The clever fella was also known for mystical and spiritual powers, which he would use to captivate people. – Adrian Cameron

As a friend and health advisor to Adrian Cameron over many years I have always found his artwork has had a deep impression on me. It has a strong connection with the Bundjalung Nation and depicts an ancient cultural connection to the land, animals and the Dreamtime.

Through his work I have gained a better understanding of the Bundjalung culture as well as the ramifications of socio-economic disadvantage of Indigenous people living in our community.

His own story of adversity is unimaginable to most of us. A journey that involved estrangement from family, residential boys homes, abuse and disrespect, racial discrimination, teenage rage and rebellion, drugs and alcohol.

Then came the incarceration roundabout of crime and gaol that is all too common within our Indigenous community. The longer term ramifications of this strife and the social damage that results require a long healing process. However in Adrian's journey there seems to be hope for him, his family and his community.

This happens to be largely through his art. This is his refuge from the chaotic world he is exposed to. Painting gives him some solace. So much safer than the past use of mind altering illicit drugs, but more importantly so much more effective in dealing with the pain of past emotional trauma.

Adrian is a talented but relatively unknown Bundjalung artist. But this may change as people recognise the depth of meaning and courage expressed through his work.

Where one heads in life depends to a significant degree on opportunity, but there is a deeper intrinsic force and spirit driving those who are born without opportunity.

Like so many others, Adrian – or 'Cheesy', as he is known - is using his creativity to build resilience and wellbeing.

Shared learning can boost GP training capacity

Researchers based on the NSW North Coast have found that teaching pressures faced by GP supervisors may be alleviated through shared learning models for GP registrars, prevocational trainees and medical students.

Dr Peter Silberberg, Dr Christine Ahern and Dr Thea van de Mortel (L-R)

However, one in four practices where shared learning could occur were not using this model to teach.

The research was conducted by Dr Thea van de Mortel (Griffith University), Dr Peter Silberberg and Dr Christine Ahern of North Coast GP Training, and Dr Sabrina Pit from the University Centre for Rural Health/North Coast.

Believed to be the first national study in this field, it offers good prospects for more efficient and effective learning, according to the researchers.

The GP training community is concerned that significant capacity pressures are looming because the number of new training places for GP registrars offered for the program in 2015 will increase by 25 per cent. Further, increased numbers of medical students will require general practice teaching placements.

The team's research, supported by Health Workforce Australia and North Coast GP Training, suggests that shared learning models may contribute to easing the GP supervisors' burden. The study, conducted over 2013/2014, involved an anonymous online survey of 1,122 Australian GP supervisors, GP registrars, prevocational trainees and medical students.

The results showed that shared learning models assisted in addressing capacity constraints, helped build collegial relationships in the practice setting, and provided a platform for learners to benchmark their level of knowledge.

GP supervisors said learning was "a more time efficient and cost effective way to teach, compared to a one-on-one mode".

Learners were happy to participate in the shared experience, with the majority expressing a preference to have a mixture of one-to-one and shared learning, rather than one type of teaching alone.

The identified barriers to using the shared learning model included lack of space and inadequate small group facilitation skills for GP supervisors. If such issues can be addressed, there is the potential to increase the model's uptake, and this may be one way of increasing general practice training capacity for GP registrars, the authors believe.

They suggested involving Regional Training Providers to support the implementation of shared learning models.

A report on the research is available at **http://www.racgp.org.au/afp/2014/september/stakeholders%E2%80%99-views-of-shared-learning-models-in-general-practice-a-national-survey/**

Welcome to Jullums

With a new name, the Lismore Aboriginal Medical Service continues its support for the health and well-being of community members.

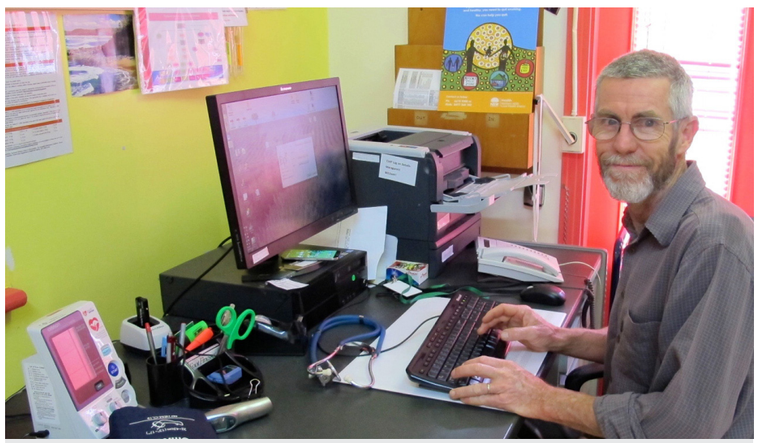
Jullums is the new name of Lismore's Aboriginal Medical Service, as depicted in the painting 'Four Jullums' which features on the signboard outside the Uralba Street house, opposite Lismore Base Hospital.

Bundjalung artist Adrian Cameron, who created the striking work, said, "This painting represents our people from the 'Widjabul Bundjalung' coming together in the form of 'Jullums', they are sitting around the meeting circle talking about individual health problems. The herbs, plants and berries represent the medicines used for wounds and illness."

The Lismore AMS provides medical services for Indigenous patients from the city and surrounding areas, offering cover for five days a week, and a holistic health approach.

Services include Aboriginal Health Education Officers, and a range of contracted allied health practitioners – a dietician, a diabetes educator, a podiatrist, an exercise physiologist, a counsellor, psychologist and psychiatrist. It also runs a respiratory clinic, cardiac clinic and a renal clinic.

Jullums AMS staff member Teri Richardson and daughter Sienna Smith greet the day by raising the Aboriginal flag.

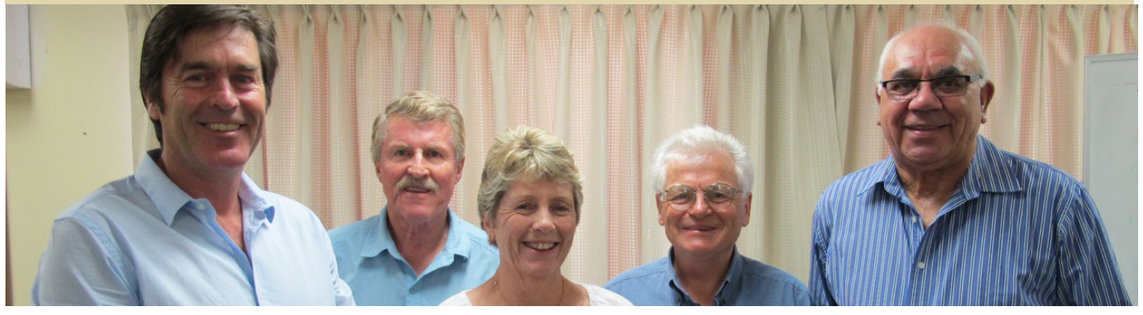


Dr Michael Douglas, Education Director of the nearby University Centre for Rural Health North Coast, is one of the doctors at Jullums. He has extensive experience in Indigenous health service provision in rural and remote Australia and PNG.

Jullums' doctors include Dr Michael Douglas, Dr Andrew Binns, Dr Carol Stevenson, Dr Anthony Solomon and Dr Jane Barker. Two nurses visit Jarjum Child Care Centre in Lismore to engage children with hygiene education. There is a close liaison with Rekindling the Spirit, a local community organisation run by Aboriginal people to benefit Aboriginal families.

Bringing them together

GPs and patients are reporting success with shared medical appointments, new research shows.



Discussing the results of the first Australian trial of SMAs were (l-r) A/Professor John Stevens, A/Professor Garry Egger , Sharon Lewis (diabetes educator), Dr Andrew Binns and Professor Bob Morgan (University of Newcastle).

Results from the first Australian trial of Shared Medical Appointments (SMAs) were revealed recently. The study, conducted by Prof John Dixon Baker (IDI Baker), and Assoc Prof Garry Egger and Assoc Prof John Stevens (Australian Lifestyle Medicine Association and Southern Cross University), showed that compared to one-on-one consultations the group visits "...lower direct medical costs, improve clinical outcomes, improve patient satisfaction, engage patients powerfully, provide peer support and maximise the value of patient time spent at the primary care office. In addition, they improve health care providers' satisfaction and enhance teamwork, collaboration."

The research focused on groups of 6-12 patients with similar concerns – e.g. type 2 diabetes, heart disease, arthritis, COPD, obesity, cancer recovery - and involved GP practices in rural (4), metro (3) and remote (1) settings.

Initial results are very encouraging with more than 60% of patients preferring SMAs to individual consultations, with 100 per cent satisfaction reported by GPs.

An Adelaide GP commented, "For me it just feels so much more relaxed than an individual consultation," while Northern Rivers GP Andrew Binns said, "SMAs lead to an increase in efficiency and helps us do health education/promotion better."

Patient responses included -

•It's good to hear other people's issues. It makes you realise you're not alone and you're not as bad off as you think."

•As a result of this group I'm more aware of my condition and therefore managing it with more confidence."

•I got so much out of this because I heard answers to questions that I always forget to ask the doctor."

A typical SMA session lasts for 90 minutes, with the doctor, who attends for 60 minutes, joined by a facilitator, practice nurse and documenter. The facilitator is seen as key to encouraging patients to feel comfortable about voicing their concerns, queries and past experiences.

According to Prof Egger, "To date, the assessment has found both clinicians and patients are overwhelmingly in favour of the process, with 100% of those patients attending saying they would come back to an SMA, and the majority stating they preferred this to a single consultation.

"The process has been particularly popular with marginal groups such as lower socio-economic status bulk-billed patients, those in rural and remote

cont on p 14

How e-technology helps people 'be appy'

Attendees at the 'R U Appy' launch in Lismore, NSW.

The launch of a Commonwealth funded training program to help Aboriginal and other health professionals better use apps and internet-based programs with Aboriginal and Torres Strait Islander clients was held in Lismore, NSW on 2 October 2014.

'R U Appy', the North Coast Aboriginal e-Social and Emotional Wellbeing Training Program, brings together work done by the University Centre for Rural Health (UCRH), the Menzies School of Health Research (NT) and Queensland University of Technology. Additional input was received from the Black Dog Institute, Macquarie University and the Aboriginal Health and Medical Research Council

UCRH Associate Professor James Bennett-Levy said, "Recent Australian developments in the use of e-mental health programs include the design of two Aboriginal-specific apps for improving social and emotional wellbeing - the Stay Strong App – developed in the Northern Territory by the Menzies School -and the i-Bobbly App, developed by the Black Dog Institute, Sydney.

"The focus of our component of this national project is to train North Coast Aboriginal health professionals to develop awareness, skills and confidence in accessing and using new technologies as an additional tool to assist their clients.

"Many young people use smartphones, but very few young people use mental health services, despite the high incidence of mental health problems.

"Online technologies and apps enable health professionals to meet people in the places where they hang out. This is particularly important for reaching younger members of the community

"Yet there are many challenges, such as the need to up-skill the health professional workforce to better engage with these new approaches and to develop strategies to effectively integrate e-tools into current practice.

"Rather than replacing the role of therapists and health workers the e-Mental Health program will further enhance their skills and resources," A/Prof Bennett-Levy added.

Project development was guided by ongoing consultation with regional Aboriginal organisations and individuals, including advisory groups in Lismore and the Tweed.

The training program will be available to all Northern NSW Aboriginal and Torres Strait Islander health professionals and other health professionals who work with Aboriginal and Torres Strait Islander people. Roll out is set to begin in 2015.

Further information from **James.Bennett-Levy@ucrh.edu.au**

Research on SMAs - cont from p 12

areas, the elderly, and Indigenous men. In our research many of these patients claim they are heard more and learn more from SMAs than in a usual care consultation. The most common statement is: "It's good to hear from others with similar problems".

The benefits noted in the study included -

For Patients

• Improved quality of, and access to care;

• Extra time with own doctor and more relaxed pace of care;

• Peer support and feedback from patients with similar conditions;

• Multidisciplinary care from a range of (2-4) providers;

• Answers to questions they might not have thought to ask (because others in the group ask)

• An additional health care choice

• Greater self-management education and attention to psychosocial issues

For Clinicians

• Increased physician productivity/cost effectiveness/time effectiveness;

• Better management of waiting lists;

• Reduced repetition of information/advice;

• An opportunity to get off the fast-paced treadmill of individual visits;

• Can contain costs while increasing clinical income;

• A chance to get to know patients better in an interactive setting;

• Real help from the multi-disciplinary team with the opportunity in Australia to coordinate Care Plan Reviews and Team Care Arrangements (TCAs)

The SMA concept was pioneered in the USA by Dr Ed Noffsinger, who came to Lismore in 2013 to speak with local GPs. It is now used in the Netherlands, Italy and Norway to increase patient compliance (mainly Type 2 Diabetes), with the current trial sponsored by a RACGP grant.

Four generations and 1,000 babies later, it's farewell to a local legend

Registrar Dr Nispa Krongkaew pays tribute to her Supervisor, Dr Betty Marks, the North Coast medical legend who retired recently at the age of 90.

This year marked the end of an era for Murwillumbah, and the Northern Rivers, when Dr Betty Marks, the longest serving doctor in town, hung up her stethoscope and celebrated her retirement at the age of 90, after devoting 66 years of her life to patient care. The retirement party, held on 19 July at the Murwillumbah Golf Club, received over 200 attendees.

Dr Betty, as she is affectionately known, is a living legend. After graduating from Sydney University in 1948, Dr Marks (nee McEwan) worked in Sydney for five years before moving to Murwillumbah with her late husband, Dr Jim Marks.

A true general practitioner and family doctor, Dr Betty has treated local patients and families over four generations, delivered over 1,000 babies, given countless anaesthetics, attended all emergencies and performed house calls any time of day or night. Only recently, I had the pleasure of meeting a 97-year old lady - still proud to tell the story 60 years on - who underwent a nephrectomy operation in 1954 performed by Drs Jim and Betty Marks.

Dr Betty practised a mixture of past and present medicine, and held fast to various tried and tested remedies, such as lotio rubra for sloughy wounds or quinine for leg cramps. In her room, Dr Betty had a microscope on her bench – a contraption from perhaps the 1800s with an external light source – that she used to look at white cells in the urine sample indicating infection, a skill long lost in today's doctors.

By the same token, she kept up with all the latest drugs on the market and knew all the new specialists in town. Right up to her retirement, Dr Betty drove herself to various GP education seminars to collect her CPD points like the rest of us.

As general practice moved towards computer-based notes, Dr Betty was not fazed. She started learning to use the computer in her 80s, and despite her inexperience, she managed the electronic database and typed all her own letters, even though she wouldn't use backspace!

I was fortunate enough to be one of last few GP registrars to work alongside Dr Betty. While I showed her how to use the printer, she showed me how to be a real doctor. Her concern for others is genuine and profound. No matter how tired she might be, she could always find more of herself to give those in need.

Only a few months before she retired, Dr Betty referred one of her patients for a colonoscopy. As the patient lived alone, Dr Betty decided to look after the patient through the bowel prep overnight in her own home, and drove the patient to hospital the next day. The lines between professional and personal lives were frequently blurred, but Dr Betty was not concerned by such matters – she cared for everyone the same way, whether they be her patient, family, colleague or friend.

Dr Betty's tireless dedication to the community earned her a Medal of the Order of Australia in 2001 for her service to medicine. Upon retirement, she featured in television news across Australia and front pages of local newspapers. At her retirement party, she was honoured with the NSW Premier's Award for service to the community, received a congratulatory message from Prime Minister Tony Abbott, and formally being acknowledged in Parliament the following day.

Health spending found to have slowed

In an age of rising obesity and mounting chronic disease, we believe Australians are becoming less healthy, making the national health budget blow out as fast as people's waistlines.

But one set of statistics suggests otherwise: in 2012-13, the latest period surveyed, estimated spending per person on health averaged $6,430, some $17 less per person than in the previous year **http://www.aihw.gov.au/publication-detail/?id=60129548871**

The new report from the Australian Institute of Health and Welfare (AIHW),

Health expenditure Australia 2012-13, said total spending on health goods and services in Australia was estimated at $147.4 billion in 2012-13 (9.67% of GDP). This was "the lowest growth the AIHW has recorded since it began the Health expenditure Australia series in the mid-1980s, and more than three times lower than the average growth over the last decade (5.1%)," according to AIHW Director and CEO David Kalisch.

In The Conversation **http://theconversation.com/health-spending-growth-at-30-year-low-31983** Fronscesca Jackson-Webb wrote that, "Health Minister Peter Dutton has used rising health costs to justify the introduction of a $7 GP co-payment, which is yet to pass the Senate…"

She added, "In 2012–13, governments funded 68% of Australia's health expenditure, 1.6 percentage points lower than the previous year. Individuals, private health insurers and motor vehicle/worker's compensation insurance programs funded the remainder of the nation's health bill."

The government would find it hard to contest the findings – as the AIHW says, it is "a major national agency set up by the Australian Government to provide reliable, regular and relevant information and statistics on Australia's health and welfare."

The online report quoted Prof Stephen Duckett, Director of the Grattan Institute's Health Program, as saying that, "A number of commentators have claimed the health system is unsustainable and this report gives lie to those sorts of statements."

Professor Duckett said it was interesting that Australian government spending had declined by A$1.5bn in real terms, while out-of-pocket costs had risen by $1.7bn.

"So there's been, effectively, a cost shift from the Commonwealth government to patients and consumers over that last 12 months.

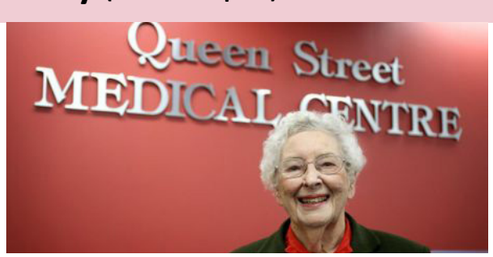
"I think that puts the co-payment issue in perspective: there's already been a shift in that direction… as I've pointed out previously, the co-payments impact particularly on the poor and … the sickest among the poor."

Internationally, Australia's health spending as a proportion of gross domestic product was 9.4 per cent in 2012, just above the OECD average of 9.2 per cent.

Most expenditure goes to hospitals (A$56bn), followed by primary care (A$53bn), with public health (A$2bn) a distant third.

Retirement at age ninety (cont from p 15)

Since her retirement, Dr Betty now has a laptop set up in her home, and for the first time, she used Google on her home computer. What was the first thing she Googled? "Pneumonia".



Dr Betty Marks, image courtesy of the Tweed Daily News

Dr Betty is an immense inspiration and a role model to all, and she made me feel proud to be a GP, even if I may never be like her.

Health at the crossroads – private meets public on primary care

***Arn Sprogis** agrees that general practice is the key to improved quality of care, but ponders what mix of public and private structures will best support it.*


Dr. Arn Sprogis

Ineffective policy making by successive federal governments has pushed the Australian health system into the first stages of a disruption that could be even greater than the impact of Medibank over 30 years ago.

This disruption is being driven by the need to resolve the three major health care and health financing challenges:

- how to best manage chronic and complex care, and by whom?
- how to best manage avoidable hospital admissions/care, and by whom?
- how to finally get equity in access to care, particularly for rural and regional populations?

The many keen observers of our health system see clear signs of major change. We have an absent Commonwealth government, private health insurers (PHIs) moving into general practice, corporate GP practice rapidly increasing, and an impending flood of new medical graduates.

Add to this mix another restructure of the primary care system, with Medicare Locals (MLs) soon to become Primary Health Networks (PHNs).

How this fits together will shape not only general practice but secondary and tertiary care, particularly hospital care. However, there are enormous opportunities for rural and regional GPs.

The key factors that will shape this change will be the effect of the Commonwealth government's shifting its health system responsibilities back to the states and the various jurisdictions' approaches to how general practice fits within a reshaped health system able to deal with the 'three great challenges'.

Today, there is a welcome increase in longevity and an unwelcome increase in chronic and complex conditions. Improving the quality of hospital care, or reducing hospitalisations, cannot be done without the central involvement of general practice.

Having finally seen the critical nature of this relationship, PHIs are acting rapidly and decisively. Nowhere is this more obvious than in the discussions around what a PHI's relationship might be with a PHN. A more radical view would be that where Medicare after 30+ years has failed to deliver equity of access and financing for rural and regional populations, PHIs taking responsibility for these populations may achieve greater gains.

If PHIs were to be given greater responsibility for financing healthcare for rural/regional populations then my view is that individual PHIs won't do it by tendering for PHN contracts. The reasons are simple.

First, the idea that an individual PHI could have a monopoly position in a defined region without deeply compromising the existing competitive arrangements with other PHIs operating in the same region makes it untenable, at least to the other PHIs.

More importantly, regional communities would quite rightly be deeply suspicious of a national corporate deciding regional resource allocations and directions in healthcare when they have no regional track record at a population level. Communities would prefer their own community members and clinicians to take leadership of the PHN.

Lastly, PHIs have little or no experience or capacity in dealing with general practice in all its complexity, although with the demise of MLs in 2015 a large number of staff with capacity and expertise will be released into the job market .

However, PHIs do have the organisational capacity to focus

Health crossroads

on the hospital avoidance and interrelated chronic and complex disease task, and act on it in real time, and over long time frames. This could deliver quality outcomes in less than the geological timeframes of government.

If PHIs and PHNs insisted on funding being equitable in rural and regional communities then for the first time in any GP's living memory their communities would achieve health care equity, and major investment in health care would be possible.

PHIs and PHNs working together would not be paralysed by electoral imperatives, populism or the need to be elected .

The mechanisms by which PHIs can act to achieve system disruption has two likely scenarios, which revolve around whether there is or isn't a relationship between PHIs and PHNs. This will depend on the level of responsibility and scope of activity given to PHNs by the government.

In one scenario, PHIs will bid for the opportunity to be preferred providers to PHNs in delivering integrated care. They would rapidly try and tie up contract arrangements with PHNs to support integrated care for their customers through individual general practices (or their corporate equivalents).

The alternative scenario is that PHNs are not given any responsibility of consequence "to integrate the care of patients". If so, PHIs will take action to ignore PHNs and deal directly with general practice, focusing on reduction of hospital admissions, reductions in variability of specialist care, and improvements in quality care.

Either way, this has the potential to lead to innovation and acceleration of the quality care movement in general practice and initiatives like the Patient Centred Medical Home may be rapidly advanced as a preferred option.

So, precisely because we have what appears to be a policy vacuum, or at least policy silence, we may finish up with changes to primary care health systems which once started will lead to a very different health system and a radically changed experience for our communities.

Whichever way things go for PHNs, PHIs will play a key role in the process in major cities, although it is unclear what the possible consequences might be in rural and regional areas. What is clear is that general practice is the key to success in improved quality of care.

In simple terms, the dominance of secondary and tertiary care systems has peaked and that of Primary Care is on a rapid rise. The only question will be what organisations will take on the challenge and therefore be the disruptors of the current system. It is likely the most focused organisations with the clearest objectives will dominate, and PHIs and PHNs are the most likely to take on that role.

It lies with rural and regional GPs to seize the opportunity that a major disruption will provide to improve the health care financing and provision for their communities.

Advanced Maternal Age – An Obstetrician's Perspective

There are both challenges and advantages to parenting at older age, writes Dr David Addenbrooke.

Women are increasingly delaying pregnancy until later life. The reasons for this are many and solid arguments could be made regarding the increasing average time in education and training, modern gender equality in professional careers and the increasing economic pressure for double incomes, particularly in urban centres.

There are clear advantages to starting a family with a higher level of emotional maturity and financial stability. The biology of aging however does not discriminate and it is also clear that fertility and pregnancy can become more challenging with time. The biological clock is ruthless when it comes to reproduction.

In obstetric circles, the move towards becoming an "elderly primipara" begins in the mid thirties.

The first reassuring statement to make about "advanced maternal age" is that outcomes remain generally good and no woman should be discouraged from undertaking a pregnancy based purely on age. There are a number of undeniable challenges though, which come largely down to three factors. Older eggs. Older bodies. Older minds.

Every woman is born with their entire lifetime supply of ova, dormant in primordial follicles until, with each menstrual cycle, a cohort are signalled to undergo meiotic division. With age, errors in meiotic division become more common and chromosomal nondisjunction produces imbalanced gametes more frequently.

Dr David Addenbrooke MBBS BSc BA FRANZCOG Obstetrician and Gynaecologist Lismore Base Hospital

Not only is this the basis for the ever-increasing risk of aneuploidy in embryos with advancing maternal age, but it is also a primary reason for higher miscarriage rates and lower conception rates with age. The stigma of age 35 came about because, statistically, the risk of aneuploidy in an embryo approaches the risk of intervention by amniocentesis after this age.

With modern technology we are now able to offer non-invasive screening, and more recently non-invasive diagnosis. All women, regardless of age, should currently be offered aneuploidy screening.

Once a healthy embryo is carried to the second trimester we must consider the additional challenges of the "older body" of the elderly pregnant. Many women are now embarking on pregnancy with pre-existing chronic conditions developed in their thirties or forties.

The older body may be less adaptable to the physiological changes of pregnancy. Conditions such as pregestational diabetes, thyroid dysfunction and autonomic disorders should all ideally be optimised prior to conception. Even in previously healthy women, physiological complications of pregnancy such as gestational diabetes and hypertensive disorders are more common with age.

It is good practice to offer women of advanced maternal age glucose tolerance testing at diagnosis of pregnancy, in addition to routine screening at 28 weeks. Early baseline renal and liver functions can also be useful to exclude pre-existing impairment.

A number of other conditions can be adversely influenced by the hormonal state of pregnancy. In particular, we must maintain vigilance for signs of venous thromboembolic conditions and breast cancer – both

Maternal age - by Dr David Addenbrooke

of which are higher risk with advanced age in pregnancy.

Moving forward to the third trimester, there are small but significant associations with age and placental dysfunction. Preterm birth, low birthweight, placenta praevia and placental abruption are all more common with age, though the absolute risk remains low. Importantly, the risk of unexplained stillbirth at term begins to rise after age 35.

Many units are now adopting a policy of early induction of labour, close to term, for women 40 and older. Alternatively, increased fetal surveillance should be offered to those women who wish to await spontaneous labour after term.

When labour occurs, the elderly primipara is more likely to have abnormal progress (particularly second stage) and statistically more likely to be delivered by Caesarean section, either planned or emergent. Vaginal birth should still remain the preferred mode of delivery when appropriate, regardless of age.

There are both challenges and advantages to parenting at older age. A few of the considerations include a generational peer gap and the potential for health burden with ageing parents during the child's adolescence and young adulthood.

It is important to be mindful not to stigmatise women undertaking pregnancy at older age. I am often struck by how many women feel the need to justify their "pre-menopausal" pregnancy, despite the fact that these are often more considered and desired pregnancies than those of the younger cohort.

Despite the factors outlined above, it remains important to congratulate these women on their choice and support them with information in a non-judgemental manner.

How safe to birth after 40?

As the number of older new mothers increases, GPSpeak looks at the medical and lifestyle indicators that can affect mature-age birthing and parenting.

The number of Australian women giving birth over the age of 40 has surpassed the ratio of teenage mothers for the first time since 1932, according to new figures from the Australian Bureau of Statistics.

The ABS data shows that 15.4 babies are being born to every 1,000 women aged 40-44 years, while the same sized group of 14-19 year olds is bringing 14.6 babies into the world.

Commentators such as demographer Bernard Salt have attributed the pendulum swing to "the whole philosophy of postponement... of commitment, of marriage, and of having children."

In Australia, women are now averaging only 1.83 births, down from 3.5 babies in the early 1960s.

From the AIHW's latest annual report on birthing data, Mothers and Babies 2011

http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545698

we learn that a total of 297,126 women gave birth to 301,810 babies, with the average maternal age being 30.0 years, compared with 29.4 years a decade earlier.

Approximately 43 per cent of these women were having their first baby, with the average age for first time time mothers being 28.3 years. Around 3.9 per cent identified as being Aboriginal/Torres Strait Islander, and their average was 25.3 years.

In terms of older mothers, the report shows that 40-year-olds and over made up 4.3 per cent of women giving birth in 2011. Compared with the slower incremental changes in other data, this is highly significant: it increased by nearly half from the 3.0 per cent of >40s recorded a decade earlier.

In the specific 45+ bracket, some 630 Australian women gave birth in 2011, accounting for 0.2% of new mothers.

Dialysis or death – grim choice for end stage renal patients

Robin Osborne reviews an art exhibition highlighting the runaway rates of Indigenous kidney disease – yet not a single Aboriginal person was depicted.

Q: What do the following well known Australians have in common?

Tony Abbott, Joe Hockey, Julie Bishop, Christopher Pyne, Clive Palmer, [Northern Territory Chief Minister] Adam Giles, John Howard, Gina Rinehart, Andrew Bolt, Cate Blanchett, George Pell, and Paul Kelly [the singer not the journalist].

A: None of them is on renal dialysis, nor as far as we know, facing a diagnosis of chronic, let alone end stage kidney disease (ESKD), unlike so many Indigenous Australians.

This is the point of a confronting new exhibition by well-known NT artists Chips Mackinolty and Therese Ritchie, who, like the clearly recognizable celebrities, are also shown hooked up to dialysis machines.

Get well soon! A diagnosis is expected to tour nationally after its Darwin run at photographer Dave Hancock's Gallery Two Six. Its aim is to highlight a leading cause of illness and death amongst Aboriginal people – and not just in the NT.

"What if rich, powerful and/or influential Australians were - there but for the grace of God - facing the same predicament that is experienced by hundreds of Aboriginal people in remote areas of the Territory, South and Western Australia with ESKD?" Hancock asks.

Not happy, John... former PM John Howard depicted in the dialysis chair by artist Therese Ritchie.

"In a series of sympathetic portraits... life on dialysis is depicted as one of fear, sadness and dejection - and even anger. The artists are asking all of us to 'walk in the shoes' of fellow Australians whose health outcomes are poorer than the rest of Australia."

The work of Mackinolty and Ritchie, both of whom are familiar with Indigenous health services, is represented in major public and private collections in Australia and overseas. A major retrospective Not Dead Yet toured Australia recently, with Canberra its most recent stop.

"On a Darwin verandah, the idea took hold," they explain in the catalogue.

"Aboriginal people in the remote areas of the Northern Territory, South and Western Australia face potential life sentences with end stage kidney disease; people as young as 22 years old face a dire future.

"A life 'on the machine'; a life waiting for the possibility of a transplant; a life moreover that largely involves removal from kin and country in a dwindling existence that affects family and community alike. Hardly 'palliative care'."

Referring to the portrait subjects, they note that, "the 14 people depicted all have families—some no doubt large, extended families. They live in interconnected communities and social networks and are financially comfortably well off. Barring fate or mishap, they have a better than reasonable expectation of healthy and productive lives.

"We wondered if things might not be different if prominent Australians - from the Arts to Media to Politics, all with the potential to affect public opinion and policy - had end stage kidney disease themselves: waiting for a transplant... existing 'on the machine' for 5 hours a day, three times a week."

"At the time of his death, Charlie Perkins was one of the longest surviving kidney trans-

Dialysis or Death

plant recipients in the world.

"More recently, the nation lost educator, musician and Australian of the Year Dr M Yunupingu to ESKD. He had been undergoing dialysis in Darwin for a number of years, and in the last months of his life he was able to undertake dialysis in his community, instead of 650 kilometres from home. He died before a transplant was possible."

The artists add, "Chronic diseases and associated risk factors are responsible for approximately two-thirds of the life expectancy gap between Aboriginal and non-Aboriginal people. For

Dialysis self portraits... artists Chips Mackinolty (above) and Therese Ritchie (below) .

males in the NT, this stands at around 17 years, with a national average of 11.

"From 2004 to 2006... CKD was directly attributed to 4 per cent of deaths, and linked to a further 12 per cent of deaths. Kidney disease is associated with an increased risk of death and disability, and to be closely linked with cardiovascular disease—both acute myocardial infarction and stroke - along with diabetes.

"More than 40 per cent of adults attending Aboriginal primary health care services across the central Australian region have either proteinuria or reduced kidney function - the main indicators of early stages of CKD.

"The rates of ESKD rates in remote areas are up to 30 times the national average.

"Based on ANZDATA Registry analysis, from 1999 to 2009, the number of people receiving renal replacement therapy – dialysis - from Central Australia more than tripled from 62 to 209.

"At present, there are some 558 Territorians undergoing dialysis—98 per cent of whom are Aboriginal. Current estimates are that this will grow by 4.5 per cent a year."

Cycle safety on Lismore's radar

Lismore City Council has decided to include cycling safety as part of the CBD traffic study, which will be undertaken in 2015. One possible initiative could be introducing dedicated cycling lanes in or around the CBD.

The decision follows a motion at this week's council meeting by Greens' councillor Vanessa Ekins who cited safety grounds as the reason for considering marked bike lanes and driver education.

In recent months a number of cycling accidents have occurred in the Northern Rivers, some of them serious, although mostly on out-of-town roads. The risks of cycling are highlighted in the previous issue of GP*Speak*.

Cr Ekins said motorists often disregarded the rights and safety of cyclists, but may be less inclined to do so if cycleways were properly marked.

She told Council, "I highly recommend that an investigation into safe cycling in the CBD be carried out. However I believe it appropriate to leave all options open and not pre-empt the outcome of the investigations."

Does the health system 'get' Aboriginal dialysis?

Robin Osborne
Editor GPSpeak

In a series of journal articles co-authored with collaborators who included the University Centre for Rural Health North Coast's Prof Lesley Barclay and Dr Shawn Wilson, then-doctoral researcher Liz Rix raised important questions relating to the provision of hemodialysis (HD) services to Indigenous people.

As the title of one paper (Rural and Remote Health, 3/6/14) bluntly put it, 'Can a white nurse get it?'

The study concluded that the challenges faced by Aboriginal patients negotiating a system where racism and victim blaming are institutionalised can be mitigated by clinicians engaging in "three layers of reflexive practice... examining self within the research, examining interpersonal relationships with participants, and examining health systems."

This theme, which emerged from research involving HD patients in northern NSW, was explored further in the BMJ Open ("Service providers' perspectives, attitudes and beliefs on health services delivery for Aboriginal people receiving haemodialysis in rural Australia", 29/10/13, and "Beats the alternative but it messes up your life: Aboriginal people's experience of haemodialysis in rural Australia", 17/9/14), and a major contribution in Hemodialysis International 2014 ("The perspectives of Aboriginal patients and their health care providers on improving the quality of hemodialysis services: A qualitative study").

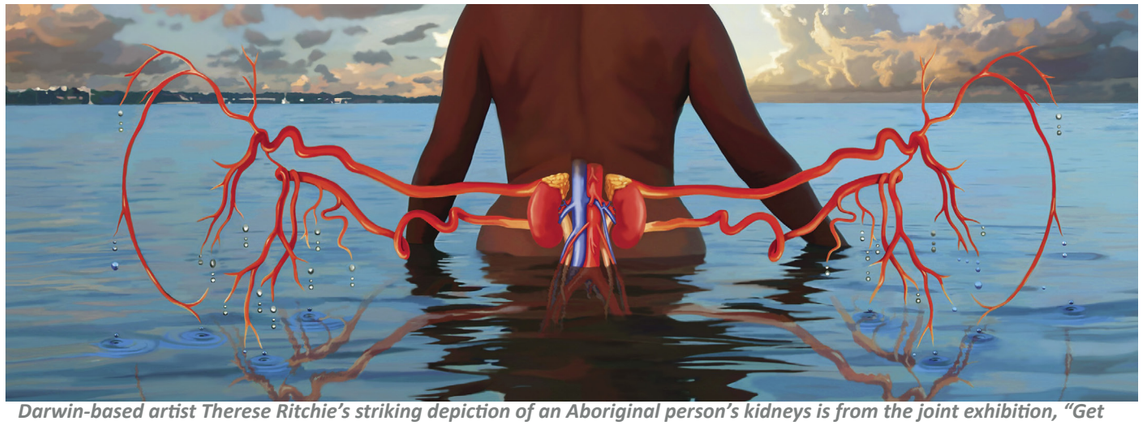
"Under an overarching theme of "Avoiding the 'costly' crisis," we identified four pragmatic themes that relate to the goal of service improvement," the authors said.

These were engaging patients earlier; flexible family focused care, which incorporated better engagement at diagnosis between services and family, and more flexibility within services to encompass family and cultural obligations; managing patient fear of mainstream services; and service provision shaped by culture.

"Patients and health care providers believe that current services are not flexible, optimally accessible, or family focused," the authors concluded.

"Aboriginal specific services and support mechanisms need to be embedded within a redesigned system. This may not only provide services that are more effective and efficient, it is likely to be less "costly" to the system and certainly less "costly" to Aboriginal patients and family."

These themes are core features of the Patient Centred Medical Home as espoused and promoted by the Northern Rivers General Practice Network and the North Coast Medicare Local.



Darwin-based artist Therese Ritchie's striking depiction of an Aboriginal person's kidneys is from the joint exhibition, "Get well soon! A Diagnosis", with printmaker Chips Mackinolty. For many years these acclaimed artists have been highlighting social issues in the NT. The show will be touring nationally in 2015.

Builder chosen for Casino Hospital ED

The tender to redevelop the Emergency Department at Casino & District Memorial Hospital has been awarded Woollam Constructions.

Announcing the successful tenderer, the Federal MP Page Kevin Hogan said, "It is well known that the current ED at Casino Hospital has poor space utilisation and in need of a major upgrade. The Coalition Government has provided $3 million to the Northern NSW Local Health District to fund this redevelopment."

Kevin Hogan and NNSW LHD Executive director Lynne Weir (left) brief Assistant Minister for Health Senator Fiona Nash about the upgrade of Casino Hospital ED during a recent visit.

The ED redevelopment will include a new triage area, two new resuscitation bays, four new treatment bays, redesigned ambulance entry, a dedicated ED staff room and improved security.

The project architectural and project management packages were let to Granatelli and Stone, Architects who completed the design phase of the program.

Woollam has offices in Ballina and employs local tradesmen.

"This is fantastic news for the Casino ED staff, who have been working in difficult conditions for some time now. This upgrade of the Casino Hospital ED will assist the staff to attend to patients in a more timely way and therefore, be of great benefit to patients and staff," Kevin Hogan said.

Order in the House

by Kevin Hogan, MP for Page

The new boundaries for the country's Primary Health Networks have been released and I am happy to report it has remained unchanged for the North Coast.

There was some concern after a Government review that our boundary could be extended as far south as Newcastle.

After Medicare Local CEO Vahid Saberi and Chair Dr Tony Lembke spoke to me about the issue, I lobbied the Health Minister Peter Dutton and also arranged for Assistant Health Minister Senator Fiona Nash to come to Lismore to meet with the Page Health Leadership Forum so our local medical professions could talk directly to her.

The main concerns of our medicos were the local focus of the network could be watered down if its geographic footprint was too large, and also that all our local services were already working in a strongly collaborative way and it would be disruptive to expand the network.

In all, the 'no change' was a great outcome for our community, and I thank Mr Saberi and Dr Lembke for their leadership on this issue.

Work is now underway on the $3 million upgrade of the Emergency Department of the Casino and District Memorial Hospital.

Last month I announced that Ballina's Woollam Constructions had been awarded the tender for the upgrade which includes a new triage area, two new resuscitation bays, a redesign of the Ambulance entry, for new treatment bays, relocation of the waiting area, a multifunctional ED staff room, a dedicated ED staff room, a public toilet and improved security.

This is fantastic news for the dedicated staff at Casino ED who has been working in difficult conditions for some time now. The upgrade will assist the staff to attend to patients in a more timely way.

I would like to also congratulate the State Government for funding the construction of the $15 million Multi Purpose Service at Bonalbo.

This is great news for the community with work to start mid-next year.

The new service will provide emergency care, inpatient beds, palliative care, respite care, residential aged care for those with low level dementia, provisions for visiting specialists and a range of primary, community and ambulatory care services.

Food for thought

Robin Osborne visits an iconic Nimbin valley farm to see how agricultural innovation delivers commercial success and helps local people stay healthy.

On land where generations of his forebears raised dairy cows, beef cattle and pigs, Frank Boyle grows pecan nuts and rice, not only farming these crops but value-adding to them by doing the processing, packaging and even the retailing.

"It means the difference between staying on the farm or not," Frank said, over a coffee on the verandah of 'Marlivale', the restored 1868 farmhouse where he and his wife Andrea raised their three children.

For years, the Boyles, whose home is located appropriately in Boyle Road, Goolmangar, in the Nimbin valley, were no strangers to working 'in town'.

Frank taught agriculture at Woodlawn College in Lismore, while Andrea had a position at Southern Cross University. She is still an academic, as well as working on a PhD related to tourism.

Like his younger brother, who spent time at Goolmangar public school with its most famous alumnus, Julian Assange, Frank was educated locally before undertaking further studies at Tocal agricultural college in the lower Hunter. While farming was in his blood, so was the urge to travel, and it was at the central Australian community of Yulara, near Uluru, that he met his wife-to-be, a lawyer by training, who hailed from England.

Back in the Northern Rivers, they saw the end of dairying on the family property by 1990 and started looking for an alternative pursuit. As the land is frost prone, macadamias were out, and the tree crop they hit on was pecans, native to the Mississippi-Texas area.

"America's 'national nut' is the only fresh food to ever go into space," Frank joked, saying that US astronauts munched on the highly nutritious pecan during their flights.

The Boyles started with 20 trees, later adding a few hundred, aware that they were facing a long-term project. Pecans take six years to deliver nuts, and around 10-12 years to become commercially viable. That assumes you know what you're doing. To optimise their chances, Frank went to Texas for a pecan training course.

While awaiting their initial crop, the Boyles worked off-farm, returning home each day to raise three young children in this idyllic location.

The arrival of the first nuts was hardly encouraging – "A total of three nuts for the five of us!"

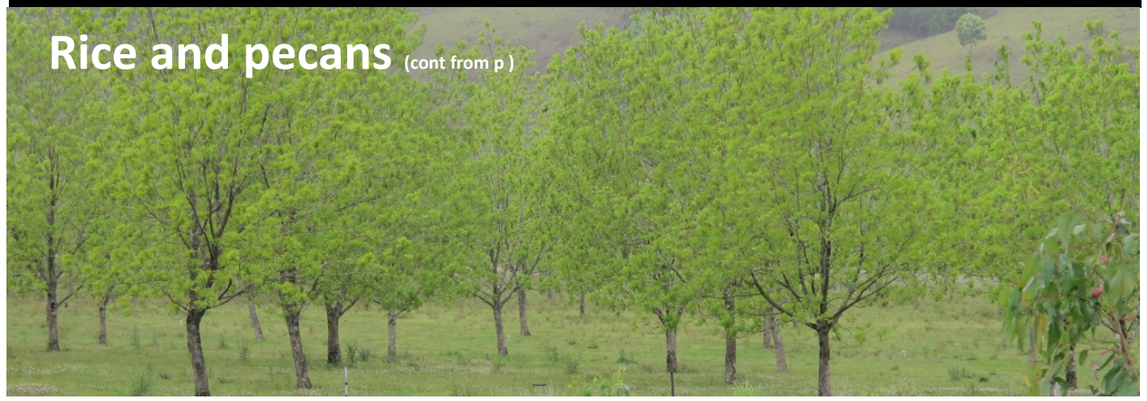
In time their patience would pay dividends. The 1,200 trees now in place yield around ten tonnes of unshelled pecans, which are harvested by shaking the trees and collecting the nuts using machinery adapted largely from the macadamia industry.

In the on-farm shed, with equipment put together by Frank, the nuts are cracked, shelled, cleaned and dried, then packaged in branded bags for sale in local shops and the weekly farmers' markets in Byron Bay, Bangalow and Lismore.

Broken nuts are added to the delicious pecan muesli they make up in their country kitchen. This product is also sold locally.

"The sad reality is that farmers receive very little for selling produce at the farm gate,"

Rice and pecans (cont from p)



Frank said, “so processing is essential to boost your return. I’m a farm boy, I never expected to be sourcing packs, dealing with marketing, graphic artists, or running market stalls…”

His lament was echoed recently by federal Agriculture Minister Barnaby Joyce who released a green paper looking at the national food production chain. Mr Joyce said it was “unjust, unfair and unacceptable” that the farmers who produce the food enjoyed by Australians and a 60-million-strong overseas market were paid an average of 10 per cent of the final price.

Moving into rice

While the need to value-add to their pecan crop came as a surprise to the Boyles, an even greater eye opener – for them and many local residents – came with their move into rice growing, an occupation that evokes images of paddy fields shimmering under the tropical sun.

Rice-farming, Goolmangar style is a very different undertaking, not least because the Japanese variety they grow is planted into dry fields, not flooded paddies, and managed as if it were a grain like wheat or barley.

Yet it was water, or the lack of it, that led to the Boyles diversifying into the legendary Asian crop that now has a strong influence on the western diet.

“Around 2006/7 there was a drought down in the Riverina, where much of Australia’s rice is produced,” Frank recalled.

“The Sunrise company was looking to expand into higher rainfall locations, such as the sugarcane areas around the North Coast.

“I went to a field day and got some seed to experiment with, both at Woodlawn, with a trial crop involving the students, and here at home where I put in an acre.”

The results came quicker than the pecans: after de-husking, that first Goolmangar planting weighed in at 2.5 tonnes, not much by industry standards, but a lot for a couple who had to pack it in 1kg bags and handle the marketing and distribution.

Significantly, they decided the product would be sold as unpolished brown rice, rather than the less nutritious white grains, and this move, along with the novelty value of rice being grown locally, resulted in the whole crop quickly selling out.

“People were amazed that we had done it,” says farm-boy-Frank, more surprised by the reaction of others than the fact that rice should grow well here.

“As we know from the popularity of the farmers markets, people are keen on local produce, and a healthy, delicious food like brown rice has a lot of appeal.” They now sell around 12 tonnes each of medium and long grain, which is after losing about 40 per cent of weight from the dehusking.

The rice crop is harvested in March-April, shortly before the pecan nut season, meaning the middle of each year gets busy for a couple that is making a major contribution to healthy eating in the Northern Rivers.

National honour for creative local doctor

Medical Educator and Associate Director of Training for North Coast GP Training (NCGPT), Dr Genevieve Yates has been awarded the prestigious General Practice Education Training (GPET) Australian Medical Educator of the Year Award.

Ballina based Dr Yates was acknowledged for her work training the next generation of doctors for the Northern Rivers Region.

In addition to her work for NCGPT, she works for MDA National (designing and delivering medico-legal education), the Royal College of General Practitioners (as an educator and examiner) and as a medical writer (columnist, novelist and playwright). She also plays violin, piano, and sings.

This year’s national GPET award was shared with Victorian doctor, Dr Gerard Ingham, who shares Genevieve’s love of medicine and the creative arts. Gerard and Genevieve co-wrote and co-produced “GP the Musical”, which has been performed in Melbourne, Daylesford and Darwin, and had a sell-out season at the Melbourne International Comedy Festival last year.

Genevieve was not only nominated for the award by her peers at NCGPT but also by numerous junior doctors she trains and mentors.

Local registrar Dr Clare Collins has said “Genevieve consistently goes above and beyond for NCGPT registrars. Her caring, passionate and enthusiastic manner is inevitably a large driving factor for our continuing success”.

Joint Medical Educator winners… Northern Rivers Dr Genevieve Yates and Dr Gerard Ingham from Victoria.

Genevieve has said of her award, “I am thrilled and humbled to receive this award and I’m utterly delighted to share it with Gerard who has been a good friend for many years.”

Always searching for ways to combine her passions, Genevieve uses film and music to help teach her GP registrars (qualified doctors undertaking General Practice training).

“Physician Heal Thyself” is a play and workshop about wellbeing and self-care issues for doctors and has been adapted for use by other Regional Training Providers around Australia.

Another project, “What Would the Coroner Think?” is a 20-minute film designed to be used as a teaching tool to initiate discussion on a broad range of themes relevant to GP training.

Genevieve is not afraid to tackle the difficult topics with subjects such as infertility, breaking bad news, and sexual harassment of doctors by patients appearing in her films and workshops.

When asked about whether her love of music and theatre would ever overpower her love for medicine and medical education, Genevieve responded, “It is easier to be an amateur actor/ musician and a professional doctor, than to be a professional actor/musician and an amateur doctor! In all seriousness, it is not a matter of choosing one over the other.

My creative pursuits are not only important for life balance and personal wellbeing but inspire and assist me to be a better doctor and educator. I try to inject my creativity into medicine and medicine into creativity. I think I’ll always be someone with fingers in many pies.”

North Coast GP Training is the Commonwealth funded Regional Training Provider delivering the Australian General Practice Training and Prevocational General Practice Placements programs on the north coast of NSW.

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.

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Shovels at the ready for Bonalbo's new MPS

Construction work on the new Bonalbo Multi Purpose Service (MPS) is set to begin in mid-2015, the state Member for Lismore Thomas George announced on 24 September 2014.

Estimated at more than $15 million, the project is funded out of the NSW Government's Multi Purpose Service stage five program and will fill service gaps that have existed in the inland town for some years.

The announcement follows the recent commencement of GP Dr Sunil Sunil, hailing from India via NZ and Coonamble, NSW who has taken took up residence, and practice, in the town.

Dr Sunil fills the large – and long-lasting – shoes of Dr Trevor Tierney who served the community for some 30 years until retirement in 2011. Locums filled the gap after he left, with Dr Kate Ealing in residence for the past year.

"Multi Purpose Services [which operate in Kyogle and Nimbin] are much-loved by communities because of its approach to delivering the specific care local residents need," Mr George said.

"It can provide emergency care, inpatient beds, palliative care, respite care, residential aged care for those with low level dementia, provision for visiting specialists and a range of primary, community and ambulatory care services appropriate for our community.

Thomas George MP (4th from left) with Bonalbo community members, NNSW LHD staff and Board Chair Dr Brian Pezzutti (3rd from right) at the announcement of funding to build a Multi Purpose Service in the upper Clarence town.

"The new MPS facilities will provide flexible services to better respond to the health needs of our community and enable a more efficient delivery of those services through improved coordination of care."

A lead design team has been appointed by Health Infrastructure to begin the process of planning and building this new facility. It comprises Mace Australia Pty Ltd (project manager) and Thomson Adsett (architect) and Altus Group Cost Management Pty Ltd (cost manager).

Health Minister Jillian Skinner praised Thomas George for his advocacy for better health services in Bonalbo.

"The NSW Liberals & Nationals Government is committed to providing enhanced health care for rural and regional communities and the MPS stage five program is a fantastic example of this commitment in action," Mrs Skinner said.

Byron's future hospital shaping up

The NSW Health Minister Jillian Skinner, with Ballina MP Don Page, Northern NSW LHD representatives and community members, recently inspected the site for the new Byron Central Hospital, costed at more than $80 million.

The current State Budget commits $1.5 million to begin construction of the project, with ground works at the Ewingsdale site set to commence soon.

tal to demonstrate the NSW Government's support for this long-awaited project, which will modernise the delivery of health care to this region.

Mr Page added, "The community has never given up on its dream of new hospital for this area and I've been steadfast in my support to ensure a new hospital for Byron has been on the government's agenda.

opened in 2012."

Minister Skinner also toured Ballina Hospital, which sees more than 9,000 patients annually, with Mr Page and the Federal Member for Page, Kevin Hogan. (Mr Hogan's seat is named after Don Page's grandfather, Sir Earle Page, a former Australian Prime Minister).

"I acknowledge the Federal Government's investment of

Artist's impression of proposed Byron Central Hospital

"It is anticipated the new Byron Central Hospital will provide emergency services, acute medical beds, low-risk maternity services following the same model currently delivered at Mullumbimby, a new 20-bed mental health unit and X-ray and medical imaging facilities," the Minister said.

"It's wonderful to be able to visit the site of the new hospi-

"The new hospital will have the capacity to care for our community for years to come. It will provide state-of-the-art equipment and attract more clinicians, which is good news for local residents.

"The Byron Central Hospital will also be collocated with the new ambulance station which has been providing fantastic care for the community since it

$4.5 million to upgrade Ballina Hospital and appreciate their commitment to redevelop this facility," Mrs Skinner said.

"I'm pleased to see investment in Ballina Hospital which has been providing first-class care to its community for decades. As a result of Federal Government funding staff will soon be able to deliver this care in a first-class facility."

Move2Change wins healthy award for Lismore

Lismore City Council has won a national award for best practice in creating healthier communities. Presented at the 2014 Heart Foundation Local Government Awards in Coffs Harbour on 20 October, the award for Lismore's Move2Change was in the category of 'Councils with populations greater than 15,000'.

Members and instructors of the Heartmoves group

The winning program delivers low-cost exercise programs through the Goonellabah Sports & Aquatic Centre and in Lismore's villages.

"Lismore City Council received this national award for their commitment to creating an environment that is a healthy and vibrant place to work and live, supported by numerous key initiatives," said Kerry Doyle, Chief Executive of the Heart Foundation NSW.

"Local governments play a pivotal role in introducing structural change, implementing policies and creating supportive environments which allow people to be physically active, reduce smoking and improve their nutrition."

The Awards recognise the achievements of local governments in the continuing fight against heart disease, the number one killer of Australian men and women.

Move2Change included a variety of programs, from gentle exercise classes for those at risk of heart disease, diabetes and other chronic conditions to community garden workshops for older people who wanted to make friends and get their hands dirty.

The programs were targeted at groups in the community that traditionally have trouble accessing health programs including the unemployed, people with disability, seniors, carers, Aboriginal and Torres Strait Islanders, refugees and people from non-English speaking backgrounds.

Move2Change was funded by the federal government and administered by Council. It involved 26 programs that were attended by 829 people. Classes are now self-sustaining, with local health professionals taking over the programs once the funding ended in June this year.

Council also supported the initiative by adopting a Health Promotion Policy and developing healthy environments though infrastructure, a smoke-free CBD and support for breastfeeding at all Council facilities.

Peter Morrow (partner)

Kris Graham (partner)

Nine Ways To Avoid A Tax Audit

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

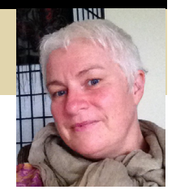
International transactions with tax havens and related parties are a key area of focus for the ATO.

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

Complex Developmental Trauma



by Sharon-marie Hall

Principal Psychologist/Consultant - Premier House Psychology, Lismore

Introduction

In 2009, Bessel Van Der Kolk and colleagues worked on defining Developmental Trauma for the purpose of inclusion in the DSM5. It was not included in the much-criticised 2013 update of the Manual, but real life tends to lead the way, and it is well accepted that people have been treated for this condition for some years.

Complex Trauma refers to exposure to traumatic events in childhood and adolescence that are unresolved, multiple and often occuring within the person's closest attachment relationships. Types can include :

- Physical sexual and emotional abuse
- Neglect
- Separation and loss
- Witnessing Domestic Violence and Community Violence.

The Developmental aspects of the description describe the way in which the complex trauma disrupts and changes the natural development of attachment in the person's psyche as well as biological processes, affecting regulation, increased dissociation, behaviour, cognitive processes and concepts of self.

Indeed, trauma changes the whole person.

Complex Developmental Trauma has traumatic stressors which are usually interpersonal. The trauma is premeditated, planned, often repeated and prolonged, and the impacts are cumulative.

Children who grow up in environments without safety, comfort and protection develop coping mechanisms to survive and function. They may be overly sensitive to the moods of others, always observing them to figure out what the adults around them are feeling and how they might behave. They might withhold their emotion from others to protect themselves when feeling fear, sadness or anger.

As the child grows and encounters more safe circumstances (if they are lucky) the adaptations are no longer helpful, may be counterproductive and interfere with their life and opportunities.

Complex Developmental Trauma interferes with brain development and function by :

- Decreased cortex activity
- Increased limbic system sensitivity
- Decreased Hippocampal volume
- Underdevelopment of left brain
- A smaller corpus callosum
- Neuro-endocrine alterations (affected by stress in early development)
- Increased production of stress hormones (including cortisol production)
- Decreased thyroid production
- Impact on gene expression in relation to susceptibility to stress hormones

GPs may meet individuals with Complex Development Trauma impacts who are children, young people or adults. Sometimes you may have some information from a mental health practitioner (or the patient themselves) that the person has Post-traumatic Stress Disorder or they might have been diagnosed with another mental health problem that is often associated with trauma. These can include Panic, Depression, Suicidality, Drug Abuse, Dissociation, Bipolar, Schizoprenia, Eating Disorders and Personality Disorders.

Often, however, you may be meeting the adolescent or adult with another of the biological consequences.

Examples of presentations common in general practice might be the effects of smoking, obesity, physical inactivity, diabetes, stroke, cancer, liver disease and other chronic illness (Van der Kolk, 2005).

The broad impacts of Complex Developmental Trauma highlight the importance of asking specific questions about trauma and the number of incidences of trauma in childhood and adolescence as part of assessments

Complex Developmental Trauma - (cont from p33)

of new and existing patients.

Adults Surviving Child Abuse (ASCA) Practice Guidelines for Treating Complex Trauma and Trauma Informed Care and Service Delivery are an excellent guide and summary of the impacts of, and treatment for, Complex Developmental Trauma.

These guidelines provide practical steps for setting up a service that puts trauma assessment at the front of clinical practice for GPs and Mental Health Professionals.

For a considerable time GPs treating patients with mental health concerns have been effectively diagnosing those with multiple interpersonal traumas as having PTSD. The difficulty for these clients in mental health settings, especially inpatient and psychiatric settings, is that the complexity of their daily life was not fully understood. The reason is that traditional approaches to PTSD focus almost exclusively on reducing a person's reactivity, intrusive thoughts and avoidance (hyperarousal).

Patients with Complex Developmental Trauma impacts are likely to feel like failures in these treatment settings because the interventions were not addressing the full range of their symptoms.

The more complex reactions to trauma seen in Complex Developmental Trauma of hyperarousal and hypoarousal (dissociation) vary more widely, change considerably over the treatment period, are more difficult to treat and require practitioners with specialist understanding and knowledge.

So what makes Complex Developmental Trauma so knotty ?

The answers to this question might make for several other articles, but I can outline some key complications.

1. The ongoing impact of a disruption to normal attachment in development which affects developing brain structures and brain chemistry.

2. The risk of coping strategies becoming personality traits.

3. The negative self-assessments that people with complex trauma make underpinning their world view.

4. The range of social impacts on the person, including the expectation that people will harm them, the belief that there is no such thing as interpersonal safety, a severe damage to the person's ability to trust, impacts on esteem, limited capacity for intimacy and an injured sense of control.

5. Dissociation often is a key feature.

It is likely that the sufferer of Complex Developmental Trauma in adolescence and adulthood might be struggling with such circumstances as :

- Their ability to trust others
- A negative view of the world
- Disruptions in relationships
- Frequent crises
- Emotional regulation difficulties
- Depression, anxiety and addictions
- Personality Disorders and suicidal behavior
- Higher numbers of physical problems

It is important to consider the trauma in the histories of clients who present with such clinical pictures. Strategies to keep traumatised patients engaged in your practice are worthy of consideration as frequent crises and interpersonal challenges can result in regular GP changes and interruptions in care.

The main features of treatment for Complex Developmental Trauma are Safety, Processing and Integration. The creation of safety in all therapeutic relationships is the absolute core of effective trauma treatment and only after the development of safety (which could take many months) can the processing of traumatic events and integration into a new world view begin.

Sharon-marie Hall is the Principal Psychologist at Premier House Psychology based in Lismore. Premier House Psychology is a Private Practice with 5 practitioners with anxiety, depression, grief and trauma as major areas of referral for adolescents and adults. Sharon-marie has been a Psychologist for 22 years, is a published author of anxiety self-help book No Worries and specialises in training other practitioners in trauma work.

Book Review

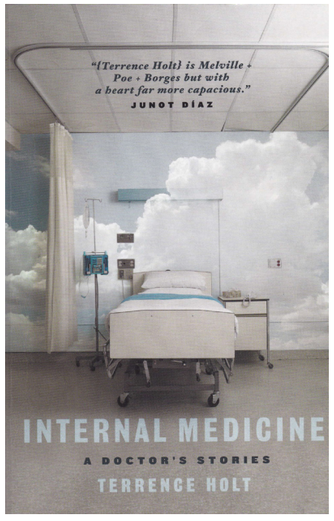
Robin Osborne
Editor GPSpeak

Internal Medicine – A Doctor's Stories

Terrence Holt

Black Inc $27.99

This 'collection of essays about life as a surgical intern' showcases the US author's parallel skills as essayist and medical specialist (geriatrics).



His previous work, In the Valley of the Kings, ranged across suspense, horror, absurdism, and more, no doubt qualities seen in ample measure in large hospitals. This time around, rather than looking to ancient Egypt (hence the title) or outer space (the setting for several tales), Dr Holt has turned his attention to non-fiction and events within his workplace, and fascinating stories have resulted.

We are by his side as he struggles to persuade a 47-year-old claustrophobic respiratory patient that a face mask will save her life. As he discusses end-of-life options with the huge, highly religious family of a dying patient. On the road with a palliative care service making home visits to a talented bird artist, suffering advanced facial cancer.

Typically, the patients at his North Carolina hospital are elderly, although the mix includes the younger unwell, and those with self-inflicted harm – the 'Iron Maiden' who has swallowed needles, and a young woman who arrives in ED with a massive, potentially fatal, overdose of Tylenol, commonly known by its non-proprietary name, paracetamol.

"I introduced myself... She didn't look too sick. "I hope you won't think I'm bad," she drawled. She said this with a sly half smile, waiting for a reaction. It was such an odd thing to say that I paused.

"Why would I think that?'

"She shrugged, still smiling. "I don't know." And slowly she slid back down to the bed."

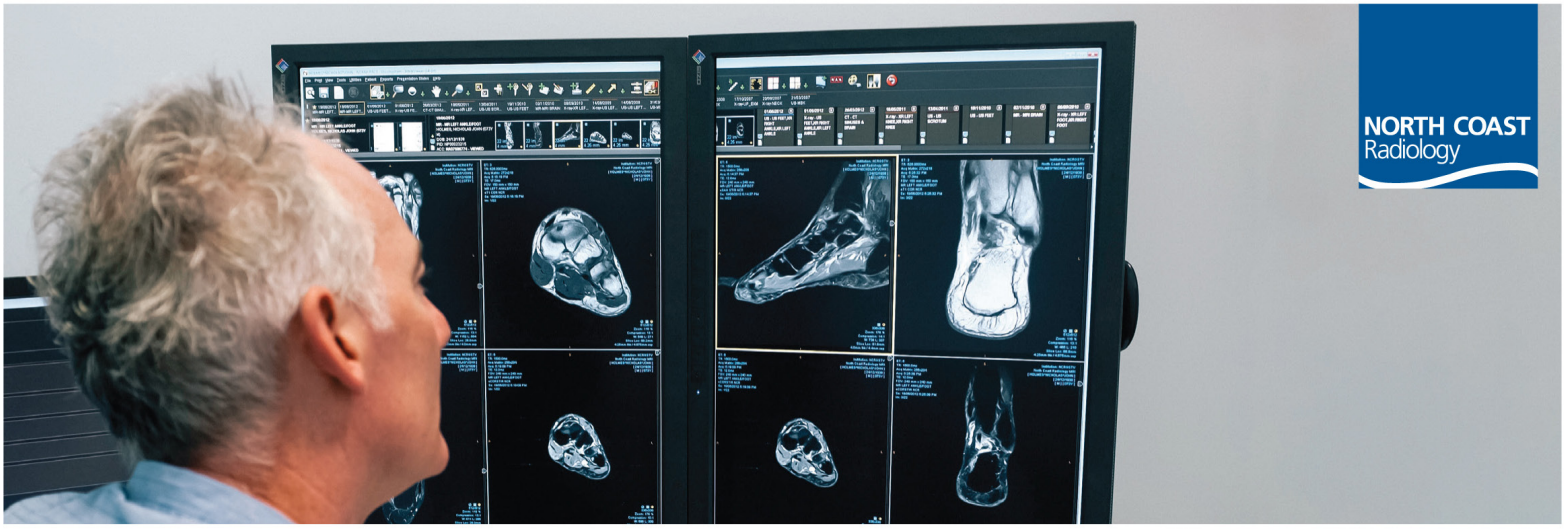
The alarm sounded when the patient's liver chemistries came back, the figures through the roof.

"In a flash I knew what was doing it, as certainly as I knew where it would end... I knew what had destroyed her liver, I knew it as surely as I knew that, for all practical purposes, Ariel Crawley was already dead."

In fact she was not, for a liver was transplanted from "the helmetless passenger of a wrecked motorcycle" and her life was saved.

"I lost eight patients that month," Holt recalls, "and Ariel wasn't one of them. She got a second chance. A victory of sorts."

Wins may not be common, but even in the losses, the human spirit and the clinician's compassion come through.



NORTH COAST Radiology

Ballina gets new MRI Service

North Coast Radiology Group (NCRG) is pleased to announce the installation of a new state-of-the-art Siemens Aera 1.5T Magnetic Resonance Imaging (MRI) unit at its Ballina branch. The MRI unit features a short wide bore & quieter exams meaning it can accommodate more types of patients as well as assist in increasing patient satisfaction.

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