GPSpeak

Special Focus:
Improving end-of-life care

New study: GP Registrars and Palliative Care

Wedgetail Retreat - Tweed facility sets the standard

Brisbane NGO helps homeless plan end-of-life

Do Advanced Care Directives suit everyone?

Funding challenge - Australia's Intergenerational Report

New books - Dr Karen Hitchcock & Dr Atul Gawande

Quarterly magazine of Northern Rivers General Practice Network

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GPSpeak
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PO Box 106, Lismore, NSW 2480
Ph: 0266 224453 Fax: 0266 223185
editor@nrgpn.org.au ● www.nrgpn.org.au

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Improving end-of-life care

GP Speak extends special thanks to the van den Berg family for their assistance with arranging the cover photo for this issue. Pictured are Johanna van den Berg, holding 'Snowy', her husband Gerry, son Raymond, and senior nurse Kelly Northeast from Wedgetail Retreat, near Murwillumbah. The facility is run by Tweed Palliative Support Inc and is the focus of one of the stories about end-of-life issues featured in this issue of our magazine.

Contacts
Dr David Guest Chair NRGPN
info@nrgpn.org.au

Dr Andrew Binns Clinical Editor
info@nrgpn.org.au

Robin Osborne Editor
editor@nrgpn.org.au

Angela Bettess graphics | web design
angela@whiteduckdesign.com.au

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GPSpeak

Northern Rivers General Practice Network

Editorial

Dr David Guest

NRGPN Chair

"Life: A sexually acquired condition that has so far proved universally fatal."

Every episode of the TV series Six Feet Under begins with a death. Some are tragic, some banal. The series is set in a funeral home in Los Angeles and follows the lives of the Fishers who own and run the family business. We follow each of the protagonists as they negotiate their life's journey, a journey which each episode reminds us will come to an end.

Statistics show that in 2010 some 70% of Australians died in hospital despite most preferring to die at home surrounded by family and friends. Atul Gawande in his latest book Being Mortal (reviewed page 27) describes the phenomenon, as a country's economic and health systems grow and become more capable, of being increasingly likely to be admitted to hospital for terminal care. However, beyond a certain point it becomes clear that no medical intervention makes a significant difference to the number of months remaining. In our dying days we hope to be pain free but yearn for peace. Dr Gawande was able to achieve this for his father dying from a spinal tumour.

We are now seeing an increasing number of Americans dying at home or in hospice care. This trend is also apparent in Australia as typified by the Wedgetail Retreat (page 13) that offers terminal care in the beautiful Duiguigan valley, west of Murwillumbah. We thank the van den Berg family, who appear on the cover, for sharing their story with our community.

Another measure of a country's progress is how well it looks after its disadvantaged. The Footprints Project in Brisbane has recognised an unmet need for their clientele of homeless and marginalised. They recently presented their program for end of life planning and terminal care support at the Sustainable Healthcare Transformation conference in Hobart (page 5).

Advanced Care Directives (ACDs) are seen as a way of limiting expensive, painful and ultimately futile medical interventions in our dying days. However, Drs Karen Hitchcock and Andrew Binns (pages 10 and 11) remind us that the final days on our journey are the hardest to foresee. ACDs should therefore not be seen as a contract or a management tool for cost effective care but as a way of opening up the discussion for dying patients to have with their families, carers and medical personnel about their wishes.

After an 18-month hiatus the recent Federal government budget has announced a further $485 million dollars for myHealth Record, the rebranded Personally Controlled Electronic Health Record (PCEHR). Progress with the PCEHR had been very slow and it is the government's hope that creating a blank record for instant upload will increase usage and value. Trials of this new opt-out approach will start in two sites in 2016.

Most Western countries are further along the path of health data communication than Australia but NSW Health has recently rolled out e-Discharges (page 8) that will make the transfer of care from hospital to general practice more efficient. This is just one component of the Northern NSW Integrated Care Project to improve the management of patients near the end of life and reduce frequent unplanned admissions to hospital.

Jayden MacRae (page 21) describes the extensive preparatory work needed to roll out New Zealand's "Shared Care Record" (equivalent to our PCEHR). Clear and repeated communication at the practice level was necessary to achieve the critical mass of participants to make the program sustainable in the long term.

The May 2015 Federal Budget did not produce any "shock and awe" this year, with many of the changes for primary care announced in advance. Primary Health Networks kick off on 1 July but have a 12-month transition period to redefine their work and scope. A long overdue review of the Medical Benefits Scheme, looking at the number and complexity of item numbers, will report later this year

With Medicare rebates frozen for the foreseeable future, GPs will be keen to see the Primary Health Care Advisory Group report that is also due out at the end of the year. Block funding for chronic disease management has been mooted as a solution to the distortions caused by fee for service.

Dr Steve Hambleton and his group have a number of overseas systems to investigate, with New Zealand again being a potential model for Australia's revised health care financing. However, given the slowness of the release of previous reports by the government, GPs should not expect any increase in government funding for some time. As such, they will be well advised to make their surgeries more financially viable and will benefit from considering their Key Performance Indicators as suggested by Matt Gilchrist (page 19).

All is not doom and gloom. Australian general practice scores well on most measures of primary care and Edwin Kruys', "UK doctors in Australia" (page 25) reminds me of my mother's saying, "There is always someone better off and someone worse off than you."

Medicare Local wins bid for Primary Health Network

The North Coast NSW Medicare Local (NCML) has been chosen by the federal government to run the North Coast Primary Health Network (NCPHN), operating from 1 July 2015.

The geographical/clinical footprint will be the same under the new structure – in North-South terms, from Tweed Heads to Port Macquarie.

While operating across this large area will continue to be a challenge, the announcement can be seen as a major 'win' for NCML as the nation's present 61 Medicare Locals will be halved to 31 PHNs.

The restructuring is the latest iteration of the Commonwealth's involvement in primary care provision, and follows a **review of the Medicare Local structure.**

One key recommendation of Professor John Horvath's review was to change the program's name in order to avoid public confusion: are Medicare Locals a place to visit to get Medicare refunds? Apparently many patients think they are.

Better alignment with Local Health Districts was another aim. As before, the boundary of the new NCPHN will dovetail with the Northern NSW and Mid North Coast LHDs (formerly the single North Coast Area Health Service).

While some of Australia's MLs were deemed to have under-performed, the North Coast operation was generally regarded as successful.

Welcoming the government's announcement, NCML Board Chair Tony Lembke said the PHNs would work directly with general practice, other health care providers, hospitals and the broader community to improve outcomes, access, quality and teamwork.

"The NCML Board and staff are excited to be given the opportunity to establish and operate the North Coast Primary Health Network," Dr Lembke said.

NCML CEO Vahid Saberi said he expects the three months leading up to the 1 July commencement will be very demanding.

"The first priority is to ensure no interruption of the current extensive portfolio of services delivered to the community."

"At the same time we need to ensure that the organisation is reflective of the Commonwealth's expectations; that our strategies are aligned to our regional and local capabilities and needs; and that our governance and management structures are fit for achieving the NCPHN aims and objectives."

Mr Saberi added, "When we submitted our application to establish the NCPHN in December 2014, we received nearly 70 letters of support from across the health and social services. We are grateful to our partners and collaborators for their trust, confidence and generosity."

Dr Lembke said a key task over the next three months will be to consult with the organisation's many collaborators in the health and community sectors.

"We appreciate that we need to work in close partnership to harness the skills, knowledge and resources of our many partners to improve the efficiency of the system and make it easier for patients to receive high quality care."

The Footprints Project

Footprints http://www.footprintsinc.org.au is a Brisbane based NGO working with people experiencing social/financial disadvantage, including homelessness. This article is based on a presentation at the recent Sustainable Healthcare Transformation conference in Hobart about the organisation's work in assisting homeless people with end of life care planning.

Lynne Megginson, RN, and Cherylee Treloar, chief executive of Footprints

Dying is a part of everyday life but many people struggle to talk about it. Facing death is even more daunting for people who are estranged from family or have no-one to care for them. In 2014 Footprints undertook a project looking at improving end of life care for marginalized clients who are socially or financially vulnerable and may be at risk of homelessness. Driven by Footprints staff who identified that the experience at end of life was less than optimal for clients, a project was undertaken in 2014 to explore ways to improve end of life care for clients.

Phase one of the project had already prepared the way by raising awareness, identifying local Palliative Care Services and improving linkages. Phase two involved case management and support of clients in the palliative phase of life, the provision of education to help staff to recognize clients who may be needing palliative care, and promotion and assistance with the completion of Advance Health Directives and Care Planning.

Limited research available from studies in the USA identified that clients who are homeless or at risk of homelessness have very unique fears around the end of life, such as not being found after they had died, who would care for pets or look after often very limited possessions.

Many clients also have fractured relationships and may have no next of kin at all. However it was identified that they are often keen to engage in talking about future plans and should have the same opportunity as everyone else to address end of life issues.

Experience during the project revealed that barriers often come from professionals rather than clients themselves and the perception that talking about end of life issues would upset the client was more a staff problem than one that concerned the client. This can only be addressed over time with education and support for staff as they start to recognize the importance to the client of planning around end of life care.

Practical issues around end of life care planning, such as difficulty printing and storing documents like Advance Health Directive were unique with this client group. Some clients don't have a safe place to store documents and some may share a fridge if they live in supported accommodation which can cause difficulties as ambulance personnel are trained to look on the front of the fridge for health related documents.

Housing managers often felt unable to deal with people who had deteriorating health needs and were keen to get them rehoused, in one case threatening to make the person homeless because they were sick. However finding alternative accommodation especially so close to the end of life is not always appropriate or possible.

It is our belief that with the right community support not only for the client but also for staff that someone can be cared for until they die in their home if they wish. Caring for clients in this group requires an individual and flexible approach. Barriers such as a sub-standard living environment, difficulty keeping in contact with clients, issues around medication safety and barriers to purchasing medication, dressings and equipment were common. This does not detract from the reality that they deserve the best ending to their life possible and their hopes, dreams and fears are similar but as unique as everyone else's.

Advance Care Planning needs to become much easier for this client group. Issues such as printing, copying, storing and carrying the documents are problematic. Wallet sized cards indicating someone's health preferences and decisions have been trialed in other countries and making decisions and wishes easier to record and carry would go a long way to ensuring this group receive the care they desire and deserve at the end of life.

A full-time Nursing Care Coordina-

Footprints

cont from p5

tor has been appointed to ensure the sustainability of improved end of life outcomes, by continuing to support staff to recognize and respond to deteriorating health needs of clients in a robust and sustainable way by providing educational resources, policies and procedures and clear referral pathways to other providers.

Linkages with health care providers continue to be strengthened through this work to ensure clients are cared for in a way that is meaningful and appropriate for them at the end of life. We work very closely with providers who do not have experience in dealing with clients with this complexity of health and environmental issues to ensure a successful outcome for staff and clients.

Footprints continually explores innovative ways to look at issues affecting clients. One of the next initiatives planned is a Death Café to enable clients to talk about death and dying in an informal and friendly environment over coffee and cake. A focus group meets to continually look at ways to assist clients to record end of life plans in ways that are meaningful and accessible for them.

A lady referred into the project was at risk of being evicted by the boarding house manager due to her deteriorating health following diagnosis of lung cancer. Footprints assisted her to remain in her own home by working closely with a palliative care provider, providing practical support, equipment and education to the boarding house manager. This allowed the lady to achieve her wish to die at home and receive the care she needed in an environment that would have struggled to cope without significant input.

Utilising a GP Registrar Palliative Care Facilitator to Reduce Admissions Amongst Palliative Care Patients

Trialling the use of GP registrars to help manage patients accessing community palliative care services has shown promising results, writes ***Dr Thea van de Mortel****, a member of the collaborative team comprising Northern NSW Local Health District, the North Coast Medicare Local, North Coast GP Training and Griffith University.*

Recent estimates at both a state and national level suggest that demand for palliative care services will continue to rise by about 5% per year, given both the ageing population and the increase in rates of chronic disease. Effective community palliative care services reduce the need for hospital admissions and support patients in their choice to be cared for at home.

Dr Thea van de Mortel presenting the preliminary research findings.

However, the majority of Australians, while preferring to die at home, actually die in hospital. Palliative care patients are often admitted to hospital for symptom management and once admitted have a length of stay that is four times the mean duration of stay for patients generally.

The National Health and Hospitals Reform Commission recommends ‘integrating multi-disciplinary primary health care services and improving access to services in the community, and better coordination and continuity of care for people with more complex health problems [and] strengthening consumer engagement and empowerment.’

Some of the suggested options for increasing consumer empowerment and improved coordination of care are to encourage patients to complete Advance Care Directives so their families and medical team are aware of their wishes in relation to care, and to improve continuity of care through better communication between GPs and specialist palliative care teams.

An innovative collaboration between the Northern NSW Local Health District, the North Coast Medicare Local, North Coast GP Training and Griffith University, which began in 2013 is making a difference to patients utilising community palliative care services in the Richmond network, in the Northern Rivers area of NSW.

The team has been trialling and evaluating utilising GP registrars based with North Coast GP Training to streamline the management of patients accessing community palliative care services. Delivery of the trial service has been funded by the Northern NSW Local Health District and the North Coast Medicare Local under the direction of Dr Kenneth Marr (Acting Director of Palliative Care Services), Ms Vicki Rose (Executive Director Allied Health Chronic & Primary Care), and Mr Vahid Saberi, CEO of the North Coast Medicare Local. North Coast GP Training CEO, John Langill and Director of Training, Dr Christine Ahern have provided support to the registrars involved in the project.

Dr Rob Walsh, a previous North Coast GP Training (NCGPT) registrar, and Dr Susan Tyler-Freer, a current registrar, provide a service to community palliative care patients that involves an initial evaluation of patients in their homes at the time they are enrolled in the service, with ongoing as- needed evaluations and care planning in consultation with the patients’ GP and Dr Marr.

The registrars liaise between the patient and their family, the patient’s GP, and specialist palliative care services, and initiate the completion of an Advance Care Directive.

The registrars also provide an after-hours service to improve service provision outside of normal business hours. The registrars use tools such as the Resource Utilisation Group – Activities of Daily Living (RUG-ADL) instrument and the Australian Modified Karnofsky Performance Scale

North Coast Hospitals enable e-Discharges

Northern NSW Local Health District has started rolling out e-Discharge Referrals through NSW Health's medical data transfer facility, HealtheNet.

For Northern Rivers general practitioners this will mean discharges from the wards and the Accident and Emergency Department will now come through the practice's usual e-health communication provider.

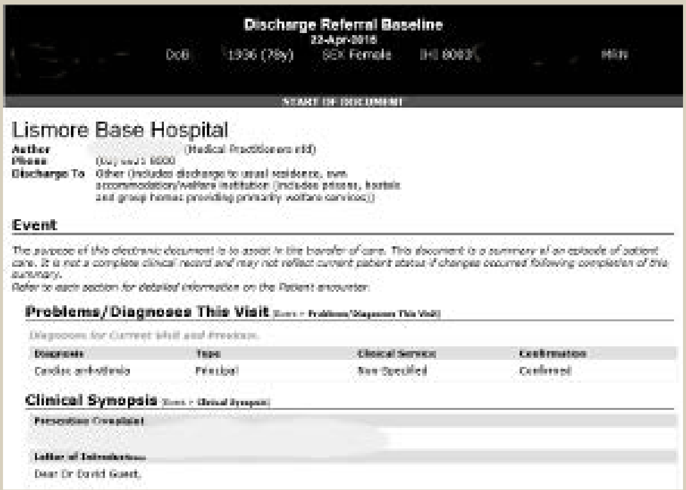
Many practitioners will be pleased to see the end of faxes from the LHD. The e-Discharges will make it easier for GPs to manage their patients' data, particularly for those patients with chronic disease who are frequently admitted to hospital.

e-Discharges will now be sent directly to the HealtheNet servers in Sydney. From there it is distributed to general practitioners through their usual e-health communication provider, such as Argus, Medical Objects and Healthlink. If patients have opted in to the Federal government's online health record, the Personally Controlled Electronic Health Record (PCEHR), the discharge referrals can also be sent there.

Currently GPs are identified in the system by their provider numbers. However, in the future practices will need to have had their **HPI-O** and their individual practitioners' **HPI-I** registered with HealtheNet.

The system will still default to sending a fax where the patient does not have their own GP but can nominate the general practice that they usually attend. However a default GP can be set up for the practice if preferred.

Transfer of data from general practice to the local hospital remains limited with the best approach being to send documents indirectly via the PCEHR. All GP EHRs are able to upload Shared Health Summaries but e-Referrals are still unavailable in some of the more popular products.



Discharge Referral Baseline
22-Apr-2015
[redacted] DoB 1936 (78y) SEX Female IHI 8003 [redacted] MRN

START OF DOCUMENT

Lismore Base Hospital
Author [redacted] (Medical Practitioners nfd)
Phone [illegible]
Discharge To Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Event

The purpose of this electronic document is to assist in the transfer of care. This document is a summary of an episode of patient care. It is not a complete clinical record and may not reflect current patient status if changes occurred following completion of this summary.
Refer to each section for detailed information on the Patient encounter.

Problems/Diagnoses This Visit

Diagnoses for Current Visit and Previous.

Diagnosis	Type	Clinical Service	Confirmation
Cardiac arrhythmia	Principal	Non Specified	Confirmed

Clinical Synopsis

Presenting Complaint [redacted]

Letter of Introduction

Dear Dr David Guest,

Preliminary Research Results

cont from p7

(AKPS) to guide functional assessment and the planning of care.

Once the patient has been assessed the registrar completes an advanced disease care plan in consultation with the patient's GP and the palliative care team. The registrars conduct routine monitoring visits on a three-monthly basis, and as-needed assessments where required. When the patient's functional status declines to a pre-determined level, an end of life care plan assessment takes place, and a Community End of Life Care Pathway is initiated.

The registrars also organise bereavement follow-up and death certification. Referral of patients into the service has been via the patient's GP or specialists.

Evaluation of the program is being conducted by NCGPT and myself [Dr van de Mortel is with the School of Nursing and Midwifery, Griffith University] with funding from a Royal Australian College of General Practitioners' Independent Practitioner Network grant obtained in 2014 [by Drs Hilton Koppe, Thea van de Mortel, Kenneth Marr, Rob Walsh and Dan Ewald].

Statistics on the number of admissions and number of inpatient days per 100 patient days, proportion of patients who are able to die at home, and proportion of patients who have completed an Advance Care Directive have been collected for patients in the intervention area and compared to those from patients in the other two community nursing areas in the Richmond Network.

To date there have been substantial improvements in outcome measures, which were reported via a presentation by Dr Thea van de Mortel on behalf of the team at the University of Tasmania's 'Sustainable Healthcare Transformation' conference in Hobart in March 2015.

For example, patients receiving the registrar service are nearly twice as likely to die at home compared to patients receiving the standard service, and are approximately four times more likely to have completed an advance care directive.

Patients receiving the registrar service have 30% of the hospital admissions required by those in the standard service [around 1.5 per 100 vs 4.5 per 100] and take up less than half of the inpatient bed days. These very encouraging findings demonstrate that collaboration and innovation can pay dividends for health services, primary health care providers and, importantly, their patients. The project partners are working to extend the project.

Intergenerational Report is a cloudy crystal ball

by Robin Osborne

Treasurer Joe Hockey and his band of Treasury officials have emerged from their crystal ball gazing to predict the **shape of Australia circa 2055**. The results, like much futurology, are a mix of data analysis, inspired guesswork and optimism.

Or if you prefer, the bleeding obvious (we will live much longer), the concerning (fewer people of traditional working age), and the how-could-you-possibly-know? (economic predictions tend to assume a consistency that changes in governments or global circumstances cannot guarantee).

One critic of the economic projections said the only sure thing about the economy in 40 years' time is that there will be an economy.

The **2015 Intergenerational Report** (IGR) does, however, contain a caveat – "Long-term economic projections present one possible outcome based on a set of well-informed projections and assumptions about future changes in Australia's population, workforce participation and productivity."

Prior to the release of the 145-page (including appendices and references) document on 5 March the Treasurer warned it would "knock us off our chairs", yet real surprises were conspicuously absent.

After the launch Mr Hockey was speaking in measured tones about how it signposted a "social compact between generations" on a road to "immense future potential." That assumes, to quote the final words of the report's summary – and to hint of federal Budget strategy - "we plan for tomorrow, today".

The IGR, the fourth to date, has been described as a political document and criticised mainly on the basis of its time-frame: who can predict how society will look four decades into the future? Only a few years ago we'd never heard of the iPhone, or 3-D printers or… governments that only endure for a single term.

Interestingly, considering the government's narrative about the health system being in need of major change, the report notes that, "Australian families enjoy access to a well-functioning health system."

It continues in an upbeat manner about "good schools, a strong social safety net and options for recreation and leisure that our grandparents could only dream about."

Of course our grandparents didn't have IGRs to tell them what today might hold.

One thing seems certain – there will be many more grandparents in the future, with life expectancy at birth projected to be 95.1 years for men and 96.6 years for women by the end of the report's timeframe.

There are projected to be around 40,000 people aged over 100, well over three hundred times the 122 Australian centenarians in 1974-75. This should keep Buckingham Palace busy with the congratulatory letters.

The IGR predicts that "improvements in health" will mean people are more likely to remain active for longer, saying this 'active ageing' presents "great opportunities for older Australians to keep participating in the workforce and community for longer, and to look forward to more active and engaged retirement years."

However, there is slight analysis about managing the burden of chronic disease that will affect so many people in the older (and the poorer) age groups.

Instead, there is a generalisation that Australians will live longer and do so in better health, and that more of us will continue to lead an active lifestyle and participate in the workforce after reaching traditional retirement age.

Regarding health funding, the report focuses on the federal government's commitment, which has been falling, rather than that of the states, which in consequence has been rising, much to the ire of the Premiers.

Moreover, this trend will continue, with the IGR projecting health will **account for a much lower proportion of GDP** than previously reported.

The greater number of the ageing is likely to increase their participation rates in the workforce, it says, with those aged 65+ projected to increase from 12.9 per cent in 2014-15 to 17.3 per cent in 2054-55 – "If they choose to," The Treasurer added hastily in his media conference.

"This represents a significant opportunity for Australia to benefit more from the wisdom and experience of people aged over 65," the report said.

Female employment is projected to continue to increase: "In 1975, only 46 per cent of women aged 15 to 64 had a job. Today around 66 per cent of women aged 15 to 64 are employed. By 2054-55, female employment is projected to increase to around 70 per cent," the IGR said.

However, the rate lags behind certain other countries, including NZ and Canada. "Policies that help to continue to boost female participation will help Australia achieve an even higher level of future prosperity."

Book Review

Review by Robin Osborne

Dear Life: On Caring for the Elderly

Quarterly Essay 57 / April 2015

by Karen Hitchcock

This 78-page essay by hospital staff physician Karen Hitchcock is a timely contribution to the end-of-life discussion that is attracting ever more attention from the medical and nursing professions, patients, families and advocates.

Dr Karen Hitchcock

Still largely missing from this debate are the voices of our politicians – many of whom would have elderly and/or ailing family members – whose leadership is vital to the better planning, and funding, of how society supports the waning days of our lives.

The reverse applies at present, as Dr Hitchcock notes: "There are many ways to show that we devalue our elderly, are repulsed by them, terrified of becoming them, "she writes early in her powerful and pointed analysis.

"They have been and remain the last priority in our medical system and the ones we target first with our austerity measures… The solutions are not simple. My chief aim is to strike a note of caution and to make explicit something that often remains unsaid and yet can be heard quite clearly: that the elderly are burdensome, bankrupting, non-productive. That old age is not worth living."

The aged are blamed for the need to "ration health care", she says, rather than the targeting of known waste such as mass pharmaceutical over-prescription, the over-servicing of patients in the private sector, and Medicare payments for useless or harmful interventions.

As might be expected, the controversy peaks around the topic of end-of-life decision making, notably about "what should we consider a sound motivation?"

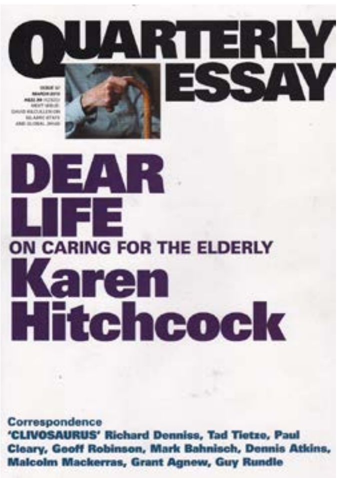
With many elderly fearing they are an encumbrance to their loved ones, clinicians must ensure they do not intensify the feeling of burden: "We must be cognisant of it and attempt to alleviate it: take the person in, let them know we carry them."

Then, in a line encapsulating the essay, she adds, "When placing limits on treatment, it is sometimes far from clear whose distress we are seeking to curtail."

Her discussion of advanced care directives is sited within this context, one noteworthy aspect being that the vast majority of ACDs, once signed, are never revisited for review.

Dr Hitchcock notes that while most adult Australians express the wish to die at home, only 14 per cent actually do, with half dying in hospital, and one-third in nursing homes.

The fact that an ideal end, what she dubs a "caesarian-section death" – pre-planned, well timed, excretion-free, speedy, neat and controlled – is extremely difficult to manage in the home setting, and as a fellow physician tells her, "Hospital is not a bad place to die… People really aren't preoccupied by their environment when they're dying. It's the people around them and the care they receive that matter."



The author adds, "In my experience, most families and patients do not want to go home once dying begins. If they do, services are terribly sparse."

This brings us back to the politicians whose silence on such matters is so conspicuous.

"Right now, we need the resources to care better for the elderly in the institutions we have imperfectly built, and we need adequate supports and deep social transformation so that many more people can live on in their communities and homes.

"We must remain aware of our ageism in every program and policy we implement. These changes are of pressing importance and they will ultimately benefit us all. Even if - for now - we believe that we would rather be dead than demented, rather be dead than dependent; rather be dead than grow old."

While the essay focuses on the elderly, the author also discusses the other end of the age spectrum, arguing that the oft-raised challenge of 'health-system sustainability' requires "urgently addressing the poor health of the younger generations."

In words that should be more prominent in documents like the 2015 Intergenerational Report, she writes, "The real tsunami is not one of age per se, but of a population of increasingly poor, obese, diabetic, sedentary young and middle-aged who are the multi-morbid patients of the future and who will require many drugs, doctors, operations (joint replacements, bariatric surgery, amputations, coronary vessel interventions) and hospitalisations."

She feels government has neglected its responsibility to encourage this demographic's wellbeing, lamenting the demise of the Australia National Preventative Health Agency, and what she calls the 'defunding' of Medicare Locals.

Patient wellbeing must drive ACDs

Dr Andrew Binns

Clinical Editor

As we digest the **2015 Intergenerational Report**, which was tipped to surprise, or even shock us, care should be taken about how the trends identified may impact on our older population.

The language is often around the 'burden of chronic disease', and whether the nation can afford to provide high quality service for an ageing population in the longer term.

The impact of this can result in older people with advanced disease thinking they are a burden on their families and on the health system. The **Quarterly Essay (issue 57), by Dr Karen Hitchcock** , (see opposite page) a staff physician in general medicine at a large city public hospital, suggests the medical profession may declare a situation hopeless and further treatment futile, despite encountering a number of older people when such a view could be questioned. She cites a number of compelling and emotional stories to illustrate her views, based largely on her own family and experience with older patients as a treating general physician.

One of her concerns is advanced care directives (ACDs) – once bearing the more ominous name of 'end of life plans' - which have gained much popularity in recent times. Some are touting these as the answer to avoiding expensive end of life care. As an example, Kate Carnell, CEO of Australian Chamber of Commerce and Industry on ABC's **Q&A 17 March 2015** said all older Australians should have an ACD to address futile overtreatment that contributes to rising health costs.

Judgment even for the best trained physician as to what treatment could be regarded as "futile" is fraught with danger. So often people with advanced chronic disease live longer than we predict, while others can die unexpectedly. Our judgment tends to be subjective and can be clouded by experiences with other patients, family pressures, hospital bed resources and health cost issues.

A recent paper from the Simpson Centre for Health Services Research, South Western Sydney Clinical School, UNSW was published in the BMJ (1) has attempted to address this issue in the acute emergency hospital setting. A newly developed checklist screening tool called CriSTAL - Criteria for Screening and Triaging to Appropriate aLternative care - is aimed at reducing the uncertainty around who are likely to die within the next three months and helping to initiate useful discussions with patients and their families about end of life care.

In the current general practice setting it is good medical practice to discuss an ACD for people whom we believe are within six months of dying.

Whether we should encourage all people around 70 years of age or older to have an ACD is questionable. Whilst there has been a push for this over the last few years there can be problems with this approach due to changing circumstances in people's lives. In addition ACDs really should be regularly reviewed and updated and this may not happen. Once the ACD box has been ticked the matter is usually left alone, and plans sanctioned by the patient rarely, if ever, revisited.

There is research to show that with proper assessment, planning and end of life care for individuals, including an ACD, a number of positive things will follow from this (2). For example, the level of active intervention requested by the patient and families/carers will be moderated, the carers and families will cope better and the bereavement process will be less traumatic for those close to a person who has passed away.

As can be seen, and as common sense would dictate, who should be advised to have an ACD cannot be based on a precise science but rather based on good communication with the patient, carers and family. GPs and their practice nurses who know the patient well are ideally placed to have these discussions with patients with advanced disease.

If the CrisTAL screening checklist is trialled in selected hospital emergency departments, as is being planned in Sydney (3), close liaison with local GPs and palliative care teams is essential in this process. This is another good reason for the roles of the primary health teams and the state's Local Health Districts to be well aligned in the interests of good quality and affordable end of life care.

References

(1) **Cardona-Morell M, Hillman K. BMJ Supportive & Palliative Care Published Online**

(2) **Wright et al, Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment, JAMA. 2008 Oct 8: 300(14): 1665-1673**

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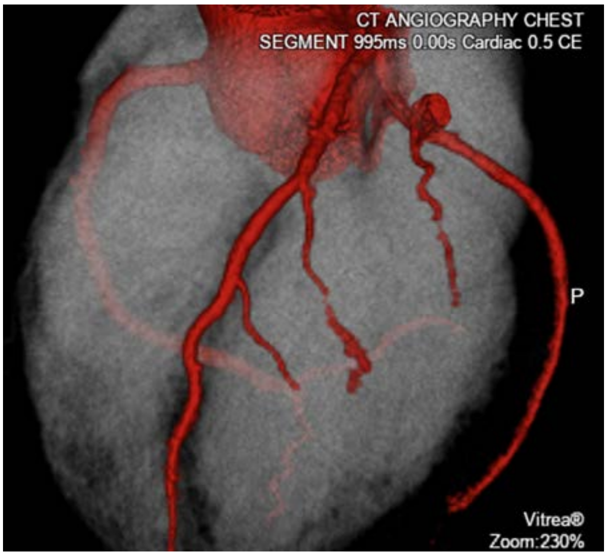
CT Coronary Angiography

by Dr Rohit Singh, Radiologist, North Coast Radiology



CT coronary angiography (CTCA) is a non invasive test for assessment of coronary arteries to exclude coronary artery disease (CAD). It involves administration of intravenous contrast, and imaging the heart with multi slice computed tomography (CT). This is done over multiple heart beats, in the same part of the cardiac cycle (with help of ECG gating). This data is then assembled to review the coronary arteries in multiple planes.

Clinical assessment prior to the scan by the referring physician is important in selecting suitable candidates for the test. This includes:

1. Patient ability to follow simple instructions
2. Normal renal function
3. Not currently pregnant
4. Able to lie flat
5. Able to hold a breath for 10 seconds
6. No contraindications to beta blockers or calcium antagonists.

If the patient's heart rate is more than 60 beats per minute, two 50 mg oral doses of metoprolol are prescribed, one the night before and one on the morning of the test. Supplementary oral and intravenous beta blockers may be required immediately before the scan. Sublingual glyceryl trinitrate is also administered during the scan to dilate the coronary arteries. A heart rate of 60 bpm or less is ideal for the test, as with even small increases in heart rate, image quality drops perceptibly.

The Cardiac Society of Australia and New Zealand (CSANZ) recommends that the test is most appropriate for patients with a low or intermediate pre test probability of CAD, who otherwise would have been considered for invasive coronary angiography. (The latter carries some risks such as bleeding.) Approximately 15% of invasive coronary angiograms are normal and substituting these with a non invasive test would be beneficial.

Recent advances in CT techniques have resulted in significant reduction in radiation exposure from the test. The most important of these are prospective ECG gated scanning and tube modulation. This means that X-rays are only used during the relevant phase (usually late diastole) of the cardiac cycle. In the remainder of the cardiac cycle there is no radiation exposure. The lowest possible tube current also helps reduce the radiation dose.

The average background yearly radiation exposure is approximately 3 mSV (milli Sieverts). As a comparison, a traditional invasive diagnostic angiogram has an average radiation of 7 - 8 mSv (higher doses likely if patient proceeds to angioplasty or stent insertion). Depending on patient size and heart rate, CTCA radiation doses vary between 3 - 6 mSv.

Meta-analyses of more than 45 clinical trials has concluded that CTCA's ability to diagnose significant disease (defined as stenosis of more than 50%) is excellent, when compared with invasive coronary angiography. CTCA has a high negative predictive value (NPV) of 96 - 100%, and a positive predictive value (PPV) of 93%.

As such, it is recommended as a tool for ruling out significant CAD in patients with stable symptoms with a low or intermediate probability of CAD.

CSANZ recommends reporting of stenoses in broad categories, rather than numeric stensoses, due to lower resolution than invasive angiography at present. These include:

1. Normal 0%
2. Minimal <25% stenosis - Medical management
3. Mild 25 - 49% - Medical management
4. Moderate 50 - 69% - Further assessment (possibly a cardiac stress stress to assess the significance of the stenosis, or invasive angiography)
5. Severe >70% - Further assessment

In addition to the above, the following indications are considered appropriate for CTCA by CSANZ:

1. Investigation of equivocal or uninterpretable cardiac stress test
2. Evaluation of new onset heart failure or cardiomyopathy of unknown aetiology
3. Evaluation of left bundle branch block
4. Mapping of coronary vasculature including internal mammary arteries before repeat bypass graft surgery
5. Excluding significant CAD before non coronary cardiac surgery
6. Evaluation of suspected coronary anomalies and complex congenital heart disease

Spirits fly high in the Tweed

The eagles weren't soaring when I visited **Wedgetail Retreat** nestled above the Dulguigan valley beyond Murwillumbah, although the kookaburras, butcherbirds and magpies made up for their absence.

> *"We can't speak highly enough of how this wonderful place and its people have helped my mum, and our family"*
> *– Raymond van den Berg*

Enhancing the idyllic scene were the distant cloud-capped mountains, a sweep of glistening canefields, and the tranquil gardens of the facility itself, fringed by remnant rainforest trees.

Nurse Kelly Northeast and volunteer Deirdre Stewart In a section of Wedgetail Retreat's gardens.

While resembling a North Coast pamper-resort, the facility caters not to 'health junkies' but to people (adults and children) with truly life-limiting illness. This is a hospice where the terminally ill, after suitable medical assessment, can spend their end days, or enable respite for their carers, in the most delightful of settings.

Residents may be accompanied or visited by family members, even a companion pet, with the added assurance of nursing supervision. An on-call physician based in Pottsville is also part of the clinical team.

Wedgetail Retreat is operated by Tweed Palliative Support (TPS), a community not-for-profit that was established in 1998 to provide cancer support and home-based palliative care services within the Tweed Shire.

Since then, with the assistance of a generous, interest-free loan from a community source, now fully repaid, TPS has purchased the land and built the infrastructure, including a storage barn for home support equipment that is loaned out free of charge.

Live-in residents may come from outside the Tweed area, with priority given to people from within the Northern Rivers. There are four en suite rooms, each with a covered verandah, while the open plan of the main building's interior has vaulted ceilings and ample space for both socialising or privacy.

Food preparation is usually done by family members who bring in their own supplies, although meals can be prepared by staff and volunteers if preferred. The main fridge is kept stocked, with each room having a small fridge so families can access their

Johanna van den Berg, with 'Snowy', husband Gerry, son Raymond and senior nurse Kelly Northeast.

Flying high

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drinks and food.

Wedgetail Retreat charges no fees to cover its substantial running costs - approaching $750,000 annually – relying on its op shops in Murwillumbah, memberships, bequests and donations, and fundraising events.

The next major fundraiser, a gala dinner at the Tweed Regional Gallery (home to Margaret Olley’s relocated Sydney home/studio) will be held on Saturday 30 May 2015.

Since its founding, as TPS president, Meredith Dennis, told GP Speak, “We have been providing emotional, social and daily living support such as transport to appointments, shopping, carer respite, loan of equipment and access to cancer and bereavements support groups.

“When we opened our first little op shop on top of the hill near the [Murwillumbah] hospital in 2006 who would have believed that only a few years later we would purchase Wedgetail Retreat?”

In fact, anyone who has seen the enthusiasm of the volunteer team, or the joy of patients visiting Wedgetail Retreat for the regular ‘pamper days’, would not be in the least surprised by their success.

“Every life matters and every moment with family or friends during their journey with life-limiting illness is precious,” Meredith Dennis added.

The energetic TPS patron is well-known local identity Margot Anthony, wife of former Nationals’ leader Doug. Another strong supporter is State MP for Tweed, Geoff Provest, who has praised the project to the NSW Health Minister.

Loan equipment volunteers John Leslie (dark shirt) and Bill Brodie, Vice-President of Tweed Palliative Support.

The impression made on leading clinicians was highlighted during the recent visit of palliative care advocate Professor Ian Maddocks AM, 2013’s Senior Australian, who spoke glowingly about the project after his talk on ‘Dying Well’.

It seems all TPS’s ducks have lined up, even if those eagles weren’t in attendance on the morning I dropped by.

- Robin Osborne

Order in the House

This month I announced the great news that North Coast Medicare Local has been appointed to run the Primary Health Network on the North Coast.

There had been concern that our Primary Health Network may be run by an organisation from outside the area. When our local health professionals spoke to me about this I lobbied the Minister to make sure our PHN was run locally. I would like to thank those who took the time to raise the issue with me. Primary Health Networks – or PHNs - are part of the Government's plans to improve the health of the nation and will replace Medicare Locals from July 1.

The PHNs will work directly with GPs, other primary health care providers, secondary care providers, hospitals and the broader community to ensure improved outcomes for patients.

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The Federal Government has announced a national taskforce to tackle the scourge of Ice. This is a very important first step in developing a National Ice Action Strategy to address what is fast becoming a major health, social and law enforcement issue in regional Australia.

The rapid spread of Ice in our community is something that I have been concerned about for some time and I have been talking with my colleagues, including the Ministers for Justice, Health, Education and Social Services about the need to tackle Ice head on.

Just last month I invited the Assistant Health Minister Fiona Nash to our region to discuss the problem with our local police.

……

This month I announced the Northern NSW Local Health District will receive more than $640,000 from the Federal Government to provide direct delivery of dementia care services across the Northern Rivers. This is terrific news and I would like to give credit to our local health district and health professionals who worked with me to ensure that continuation of this much-needed service.

The funding provides certainty for people with dementia, their carers and health professionals. The Dementia Outreach Programme, based in Ballina, assists people living with dementia and their carers.

……

I've put out a call for the local community to join the nation's largest conversation about the best ways to prevent, treat and cure diabetes, which affects the lives of most people in some way. This is an opportunity for all Australians to participate in finding the best ways to prevent, treat and cure this rapidly growing national problem.

We know it doesn't just impact those who have the disease, it takes a heavy toll on their family and friends, their job, the sustainability of the health budget and our national prosperity. It's critically important that we get a broad diversity of views. We want to hear from carers, parents, employers, doctor, researchers and anyone living with the disease.

Meet Tim Kent - from Embrace Exercise Physiology

Tim has been part of the Embrace Exercise Physiology team since 2012 and covers the Gold Coast, Tweed Heads and Pottsville areas.

Tim specialises in the fields of rehabilitative services for musculoskeletal conditions and chronic disease management with an emphasis on developing sustainable behaviour change. He focuses on in-home services for 'at risk' individuals, aiming to improve symptoms and quality of life for debilitated and elderly individuals.

Tim also has a strong interest in working with patients looking to improve their life through sustained weight loss. He believes that good health is earned every single day and that we should not take it for granted.

Tim Kent - Exercise Physiologist

When not working, Tim enjoys competing in his weekly basketball competition and exercising at the gym.

To refer a patient for in home treatment please contact Tim Kent by phone on 0432 401 328 or to 1300 212 555 or send a fax to 07 5636 1012.

FAMILY TRUSTS STILL OFFER BENEFITS

There is a tendency currently for family trusts to be overlooked in favour of self managed superannuation funds (SMSFs) as a way of managing wealth.

Yet family trusts have a number of advantages over SMSFs that shouldn't be ignored, and can be used in conjunction with SMSFs to great effect.

Family trusts have far fewer restrictions and rules than SMSFs and are therefore simpler to operate.

Other benefits of family trusts include:

- Asset protection options;
- Intergenerational wealth transfer;
- No limit to contributions to the trust and the ability to increase capital;
- Income splitting to all family members, giving substantial tax benefits, particularly where there are low, or no income earners in the family;
- No age limits to access funds;
- Ability to hold personal use assets, such as a holiday home;
- Ability to run a business through the trust; and
- Estate planning benefits.

The reasons people tend to ignore family trusts as a wealth management tool is because they believe their benefits have been largely eroded and they are seen as overly complex and expensive. In reality, they are often simpler and cheaper to operate than an SMSF.

The big attractions of SMSFs are in the tax benefits that superannuation offers as well as the flexibility they give in managing retirement savings, but the benefits of family trusts are also very significant.

Through a family trust ownership of assets such as a share portfolio or holiday house can continue on uninterrupted even if a family member dies. This is because the family member doesn't own the asset, the trust does. Consequently, the assets don't form part of the individual's estate.

Basically this makes family trusts an ideal tool for multi-generational wealth transfer while SMSFs, on the other hand, must be wound up when the last member passes away.

This potentially means all assets held by an SMSF must be sold or transferred in specie to beneficiaries. If the family wishes to keep an asset, such as property, they will be liable for stamp duty and conveyancing costs.

Those wanting to invest a substantial amount, say more than $300,000, who have either maxed out their contributions to super, or want more accessibility than super provides, may find a family trust worthwhile.

If you have any questions in relation to Family Trusts, please contact Peter Morrow or Kris Graham, Partners, Thomas Noble & Russell on (02) 6621 8544.

Kris Graham

Peter Morrow

DID YOU KNOW – SOME OF THE STRANGEST TAXES ON RECORD

- During the Middle Ages, soap was taxed in some European nations. The tax stayed in effect for about a hundred years. Great Britain repealed its soap tax in 1835.
- In 1660, England put a tax on fireplaces. Citizens began to cover their fireplaces with bricks to hide them and avoid the tax. It was repealed in 1689.
- Later that century, in 1696, England began to tax houses on the amount of windows they had. This led builders to build houses with fewer windows, which in turn caused widespread health problems. England repealed the tax in 1851.
- 1705 in Russia, Emperor Peter the Great implemented a beard tax, in hopes it would force men to adopt the clean-shaven look popular in Western Europe.
- New York City has a sliced bagel tax. The city taxes prepared food as well as general food, which means sliced bagels are taxed once as a food item and again as a prepared food item.
- In California, fresh fruit bought from a vending machine is taxed at 33%

From darkness to the light

Therapy through art for self-confessed 'doodler'

by Robin Osborne

Artist Michael Philp

Michael Philp, a Bundjalung man who grew up in the Tweed, pulls no punches when describing his childhood and adolescence. His "mongrel of a father", a non-Aboriginal fisherman, was a violent drinker who badly mistreated Michael's mother and showed little emotion towards the children.

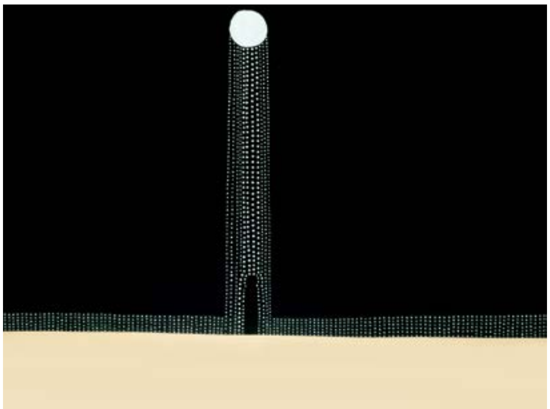
Although they lived in a beautiful part of the coast, it was a tough upbringing and there was little escape for Michael except music on the radio: he yearned to be a rock star, and would go on to formally study music.

But by the time of his teens, he had begun a descent into drugs and alcohol that would last twenty years.

"I spent those years playing with fire," Michael told a Lismore Regional Gallery talk to mark the opening of an exhibition spanning his past 15 years of sobriety.

"When I got stoned I just wanted to be out of it. I didn't want to think, I didn't want to feel, or communicate.

"It was scary to stop," added the highly talented artist whose latest works feature 'dots' in ways uncommon in Indigenous painting.



Michael Philp, *Spirit Rising, My Saltwater Murris series 2013,* acrylic on canvas, 76 x 102cm

"I came from a very dark place to the light, and while I'd done a bit of doodling over the years, I certainly didn't associate art with therapy in any way."

Panellist in the gallery talk, GP Andrew Binns discussed the therapeutic relationship between the arts (visual, singing, dancing, performance) and health, which is increasingly being recognised by healthcare professionals.

"Michael's work is a good example of how the artistic process can calm people who have had distress, including adverse childhood experiences.

"Counseling and medication are helpful, but not the only answer. Art therapy is definitely in the mix."

Despite the acclaim his works have received, Michael does not consider himself an 'artist' in the usual sense, instead regarding his paintings as a 'vehicle' for depicting the spiritual stories of the Tweed area, and his forebears' family's place within them.

As he puts it, "I try to paint from the heart... to honour those old people, I don't paint to sell."

Michael doesn't collect art, hangs his own works for only a few days, and tends not to view other Aboriginal art for fear it might influence his style.

His own journey, both emotionally and artistically, is reflected in the progression from his first body of work, the abstract and complex 'Cosmology In Me' series of black-and-white drawings, to 'My Saltwater Murris', beautifully simple paintings focusing on "identity within a fractured community and changed landscape, as a process of healing."

Michael Philp: Cosmology In Me was displayed at Lismore Regional Gallery, Molesworth Street, Lismore, until late May 2015.

Health coaching - Getting the ‘choice point’ right

Article by Sharon-Marie Hall, Principal Psychologist (left) and Jodi Jamieson, Practice Manager (right) both from Premier House Psychology.

Consider these facts:

- 65% of people in developed countries are overweight.
- The ability to retain fat makes us the evolutionary winners... if a famine were to occur we would be the grinners crossing the finish line of staying alive.
- Just this morning in the supermarket we observed eight jam-packed aisles of packaged food and one lone section of “fresh” food items.

What is available to us in Australia is unprecedented – the choice is enormous. And choice is what this article is all about.

Recently, we have both started to exercise more with the help of a personal trainer. Gyms haven’t worked for us - they do, however, seem to work well for gyms, which in the past have taken our hard earned cash and then only had to deliver a handful of classes, long before a habit can begin. As does low-carbs-high-protein or paleo or just raw food or whatever eating plan is the recommended one of the day.

We like our personal trainer. She doesn’t give too much away about what we’ll do in the next session. We train outdoors with minimal equipment and laughing is encouraged. It’s social and fun and it’s actually working. It is worth getting curious about what will work for you.

The reason most exercise and diet plans fail is not the food or the activity or the gym but the organ on top of your neck. We have all developed a lot of automatic habits about eating and moving that can be challenging to break, so eventually we find ourselves back with our old habits, often with a bit more self-loathing thrown in each time.

And the reason why we fail is because of the way we think about eating and moving. We often diet because our doctor said we should, or exercise to try to look better for someone else. We have given our power in it away to someone else, so we are not truly invested in it. What we have discovered in coaching people towards health is that new habits must be grounded in deeply held values that we can check in with when there is a decision to be made about our health.

The Acceptance and Commitment Therapy (ACT) model of change applies perfectly to health coaching. In the ACT model there are three pertinent features:

Articulate clearly your values in relation to the eating and moving and refer back to these values when you make decisions.

Have an awareness of the CHOICE POINT moment in all your decisions involving food and exercise.

Utilise mindfulness to become more aware of all the choice points in your day, and align choice point decisions with your values.

The ACT model in health coaching helps us to address the “psychology” aspect of diet and exercise, and is beautifully articulated by Joseph Ciarrochi, Ann Bailey and Russ Harris in their book “The Weight Escape” published by Viking 2014.

An example might be that Jane is exercising because her doctor rudely reminded her of her middle age status. She is shamed into exercise for a while only to stop when the pain kicks in or the first rainy day or one of the kids gets sick.

If Jane, instead, articulated valued based reasons why she would want to exercise and keep it up. Jane might say:

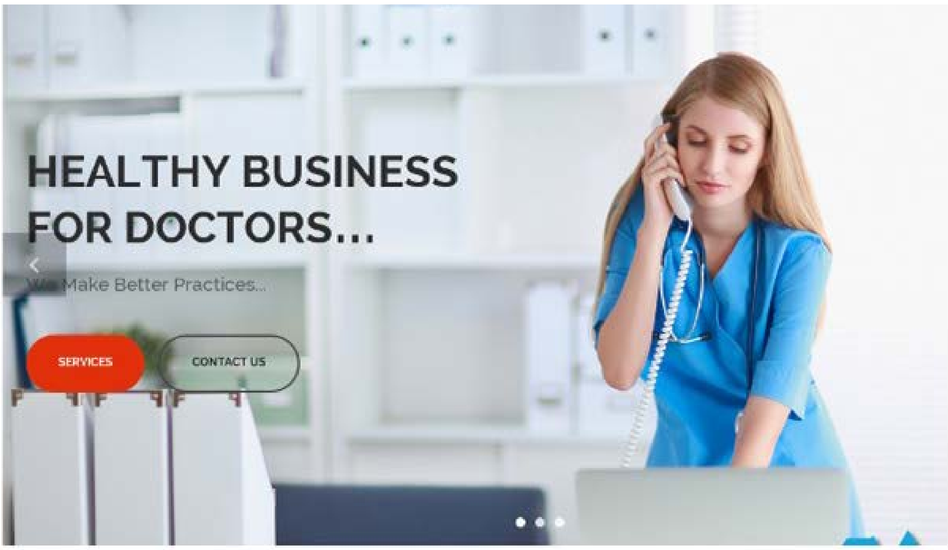
- I want to be fit and healthy to spend outdoor quality time with my kids
- I want to keep participating in sport
- I want to be strong and resilient
- I want to enjoy good health
- I want a lot of energy

At the moment where Jane doesn’t feel like training today, she can use a moment of mindfulness to note that this is a CHOICE POINT moment – a choice where she can move away from her articulated values and goals or towards them. It is her choice to make.

Once mastered, this technique works for exercise, eating changes, dealing with addictions and other health behaviours.

Health coaching teaches this effective model and supports the client toward successful maintenance of new lifestyle habits by addressing the often neglected variable in the diet and exercise equation – mindset. Lasting change can be achieved for a similar cost to that unused gym membership and those diet shakes in the cupboard going out of date.

Key Performance Indicators



Matt Gilchrist of* Healthy Business for Doctors *outlines the Key Performance Indicators for the modern general practice.

KPIs are things that your accountant probably speaks about. KPI stands for Key Performance Indicator. The following is a list of KPIs that are useful in a General Practice setting.

KPIs for Doctors

One of the large corporates refers to their doctors (to their face) as IGUs or Income Generating Units. Needless to say that this company takes their KPIs pretty seriously and they make significant amounts of money doing that. My list of KPIs for doctors includes:-

1. Number of results in inbox – This is the number of results that remain unchecked. I see many doctors who keep results in their 'Inbox' because they are waiting for more information or are trying to decide how to manage the patient. The problem with this is the rest of the practice does not know what is happening and are unable to assist the patient.

2. Patient waiting (minutes) – This is something that patients truly hate, but doctors generally do not understand. In most practices there are some doctors who always run late and others who always stick to their schedule. Those that frequently run late should review either their scheduling or consider the reasons this happens to them but not to other doctors.

3. Starting time – a significant component of minimising waiting time is to start on time. If your first patient is at 8:00 am, then be at work with enough time to get a coffee and check your results / mail and be seated at your desk ready to start at 8:00 am. If you cannot be ready at 8:00 am then schedule your first patient for 8:15 am instead.

4. Dollars per hour of patient appointment time – This is one of the financial type PKIs that accountants love. It is a way of measuring efficiency. Of course it does not consider patient outcomes.

5. Dollars per day per room – Same as above.

6. Treatment room expenses per doctor – In a perfect (accounting) world all use of the treatment room would be costed, including nurse time. In practice this is very hard to monitor and manage, but some practices do this to charge different associates different percentages.

7. Diversity of items billed – compare what item numbers are billed with your colleagues. You may just learn about an item number that you could be charging that you did not know about.

8. Patient Adverse Outcomes – It is really hard to track patient outcomes in an Australian settings, but collecting data about near misses or actual adverse outcomes is achievable and a requirement of accreditation. Collating this by doctor is not a significant challenge for most doctors.

KPIs for Reception

1. Uncompleted appointments – Ensuring that all appointments are marked as either Did Not Attend (DNA), or show completed billing. Your billing software can probably produce a report that details this information.

2. Scanning – Check the number of items that have been scanned but not allocated to patients / doctors, and also the amount of scanning left at end of day (none hopefully!)

1. Ensure that scanning settings are correct. (Namely black and white, 150 dots per inch (DPI)).

3. Online Claim Batching and all banking completed each day.

4. Patient contact are details updated at each visit as per RACGP accreditation requirements. This is important but often not done. However, monitoring this is difficult.

5. Number of billing errors. Often billing errors only become apparent when an issue has arisen. You can also check the number of reversed or amended invoices and payments via software reports on a regular basis.

KPIs for Administration / Management

1. Debtors – Check status of 'held' accounts, and monitor the aging of debtors. Ensure that all accounts are paid, especially Workcover, solicitor and insurance company accounts.

2. Check billing reports for reversed accounts, cancelled payments, and Medicare Patient Claiming. Administrators need to be sure that no one is rorting Medicare, or stealing from their employer by cancelling payments and invoices and simply pocketing money received.

3. Check cancellation of appointments – confirm with the patient that the appointment was actually cancelled if required.

4. Count and chart DNAs. Regular DNA offenders should be marked as such in the software with

KPIs for General Practice

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notes for reception staff to confirm on the day. If the issue still continues discuss with the patient that alternative care will need to be arranged.

5. Follow-up actions from Inbox – Failure to follow up recalls can be a significant risk for the practice. This needs to be regularly monitored by administration staff.
6. Unallocated Results and Incoming Letters – Practices must ensure that all incoming results and correspondence are seen by the appropriate person.
7. Online Claiming batches requiring follow up – Resubmissions need to be dealt with in a timely manner.

KPIs for Nurses

1. Recalls and reminders – Are these up to date?
2. Care Plan and Health Assessments completed – Set targets for, and compare numbers of, care plans, reviews and Health Assessments completed. Targets will be different for each practice depending on patient demographics.
3. Comparison of counts of billed GPMPs vs billed TCAs and a comparison of the total of billed (GPMP + TCA) vs billed Reviews. A review can occur for each of a TCA and GPMP.
4. CVC Program – Monitor the percentage of DVA patients on CVC (Co-ordinated Veterans Care). This program is well remunerated!
5. PIP IHI CTG registration – Monitor percentage of enrolments for eligible patients.
6. Number of Item 10997 billed – Compare billings with targets set and ALSO to the number of patients with care plans.
7. Infection rate – Monitor the number of infections per hundred or thousand procedures. If this is not very low, then an audit of the clinical processes should be undertaken.

About the Author

Matt Gilchrist is a very experienced Practice Manager with an interest in IT systems. Matt was a successful manager long before he joined healthcare. Matt has been a Rural GP Practice Manager since 2003. Matt is:-

- Senior Consultant at **Healthy Business for Doctors** (0418 877 948)
- Principal of **IT4Doctors**
- Practice Principal and Practice Manager at **Darling Downs Skin Cancer Clinic**
- Practice Manager at **Lockyer Valley Medical Centre**
- Passionate about the role of Practice Managers in the healthcare setting

NZ's first regional electronic Shared Care Record

Jayden MacRae is the CEO of Patients First, the New Zealand organisation charged with improving both the quality and ease of transmission of data in the New Zealand health sector. In this article he highlights the importance of face to face conversations with practices in the successful implementation of the NZ's "Shared Care Record".

Jayden MacRae

The need to win the hearts and minds of GPs one-at-a-time and face-to-face was one of the key lessons I learned while leading one of New Zealand's first regional electronic Shared Care Record (SCR) implementations.

I spent the better part of 18 months having practice meetings in early mornings, lunch-times and after work across close to 100 practices that covered 450,000 patients and a geographical region of 15,500 km2.

We embarked on our project in 2009 and most New Zealanders then had an expectation that clinicians in hospitals and after-hours clinics could access their general practice medical records when they presented to these care settings. At that time we were falling very short of this expectation.

The project was a part of a much larger programme of change management that had garnered support from organisational and clinical leaders, the regional funder and the public hospital system. It was consistent with the national direction of travel in the sector. It was our duty to roll-out a project that would take hundreds of disparate sources of patient information and make that seamlessly available to clinicians working in acute care settings. We already had some commercial products that could provide the technical aspect we needed but this project was not ultimately about IT. It was about relationships, trust and patient privacy.

We underestimated the mind-shift for general practices in implementing SCRs. Since the inception of mass computerisation in general practice in the late 1980s they had been operating as information islands. GPs have been the stewards of patients' greater medical history for time immemorial. We had had electronic messaging for over 30 years, but the information flows have been discrete episodic information transfers in the form of referrals, or other transfer of care information. GPs exercised control of information release as the stewards and gatekeepers of these data.

The ethos of the new world was to share a subset of all patients' medical records ready to be accessed by clinicians should they need them. The GP would no longer be an island or an active steward. It is well known that we overestimate the risks when we have little control over a threat and for some this was a hill too high to climb initially.

No amount of hard-copy material was likely to address all the questions raised and risks indented by a large number of clinicians. Large group meetings although slightly more effective than hard-copy material tended to be dominated by the opinions and views of the polarised and in such situations it was difficult to maintain a conversation along a specific thread to its satisfactory conclusion.

Meeting face-to-face with practices during their normal staff meetings was the key to providing accurate, pertinent information and gave practices a chance to understand the risks and mitigation strategies we had in place. It provided a chance to dispel misconceptions and to receive feedback.

These meetings usually involved all practice staff, including GPs, nurses, receptionists and practice managers. The format usually consisted of a short introduction to the project, its aims and some key points to address common questions, concerns and objections. Questions, comments or insights usually flowed freely after this. Everyone could ask questions or express concerns and that allowed us to address each one in turn. All were genuine, but it was often the case that the initial concerns were almost never the root objection that prevented a person or group from participating. It was therefore important to have a project representative with the seniority and project knowledge to rebut that which was incorrect or augment information to answer

NZ's Shared Care Record

cont from p21

questions in order to get to the next question or issue in the chain.

The richness and customisation of the content of the project cannot be delivered in any other way easily. It is this richness of information and the assurance it gives that was ultimately able to counter the risks and sway the majority of practices to see the project as a worthwhile undertaking.

When we encountered an objection we hadn't addressed before we were able to acknowledge it and find a way to modify the project to mitigate it. Having a face-to-face conversation meant we could do this in a way that just wouldn't have been possible in a written form. People's tone and body language can tell so much about their feelings towards a topic.

At times people articulated assent while their overall demeanour didn't and face-to-face conversations allowed us to drill down into at-times-uncomfortable conversations. I am sure that there were some things said that would never have been committed to paper or email. Their spoken words had no audit trail and this promoted a greater candour for such difficult conversations.

Having a face-to-face conversation within the practice also allowed practice dynamics to play out. The nature of the project had the practice as the smallest divisible unit of participation. Practices needed to make a consensus decision and if some providers wanted to participate and others didn't they had to resolve this internally. Everyone had a chance to express their thoughts and extreme positions tended to be taken less often than with wider group discussions. At times we were simply a catalyst for a practice to have a conversation about the benefits and risks of such a project.

We never expected to convince all practices to participate. We knew we needed over 50% of the patient population to have a record on the system for it to reach critical mass and grow. In our initial regional roll-out we got over 60% of practices participating representing over 80% of patients in the region. For large practices I often made more than one visit, in part because they were important to recruit to the project to increase overall patient coverage but also because it is difficult in large practices for all providers to attend on any given day. Also, for some it was worthwhile to reflect on the information presented and to be given an additional opportunity to ask questions at a later stage.

Using a face-to-face and personalised recruitment of practices was an extremely labour intensive and expensive approach to for this type of project. The large mind-shift that was needed to get practices to participate required a large investment and we believed that the benefits of having the SCR were worth it.

Overall the project was successful for a substantial number of reasons and ensuring we had a personalised approach to practice communication and recruitment was only one facet. It is an aspect that is easy to dismiss however, especially as you try to scale the implementation to larger areas. My advice would be to invest in people and embrace them over technology. Invest in communication, listen, challenge and understand the long term benefits of what these systems can achieve and balance this against the short-term costs to get the messages right.

The journey to any new and worthwhile destination is never easy, otherwise you'd have been there already.

Medical students farewell dinner

Dr Jane Barker (medical educator) and Flora Zigterman (UCRH student coordinator) with medical students from University of Wollongong.

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A farewell dinner and bush dance was held on the 8th May for 26 medical students from the University of Wollongong and the University of Western Sydney. The students have been completing a rural clinical placement in the Northern Rivers region for the past 12 months. One student described her experience at her General Practice "I didn't just sit in a corner all day! My GP was very supportive of me getting in on consultations, procedures and seeing what other doctors in the practice were doing eg: skin excisions, acupuncture. The nurses were fabulous to say the least, they encouraged me and showed me the ropes. I even had the chance to spend time in imaging looking at x-rays, CT scan and ultrasounds. I loved coming here."

New world of care makes HIV ‘chronically manageable’

by Dr David J Smith - Medical Director, MNC / NNSW LHD HIV/Sexual Health Services

Recent advances in the treatment of HIV infection and the benefits these confer for those with the infection and those at risk of acquiring the infection, have heralded a new world for this previously uniformly fatal condition.

Single tablet regimens. (STR) Treatment of HIV became successful in the mid-1990s but difficulties including multiple dosing schedules, handfuls of tablets and significant adverse events made life challenging for those infected and their carers.

By the late 2000s the first STR was released and in April this year the fourth of these was released, unimagined in the early dark years of the epidemic. Along with this simplification, regimens have much improved tolerability and most importantly efficacy and durability. Whilst various factors mean STRs are not for everyone, most regimens are now once daily, sometimes twice daily and involve few pills.

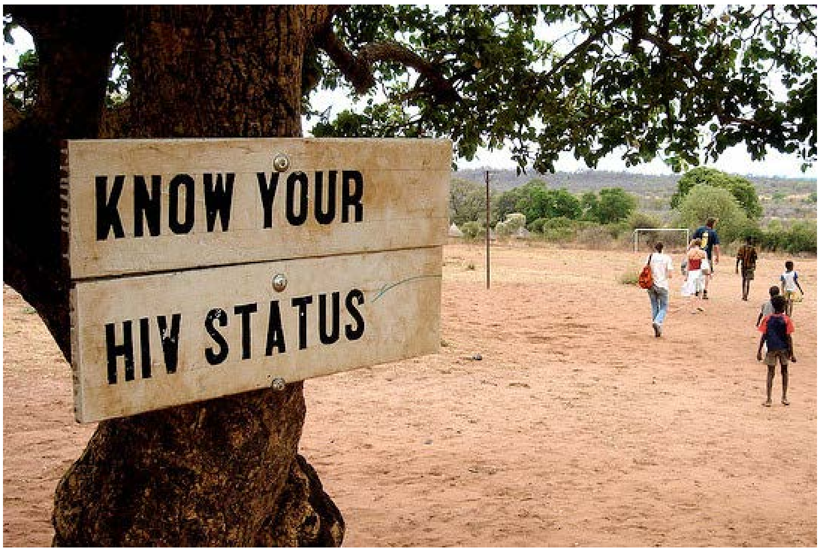

Photo “Know your HIV status” by photographer Jon Rawlinson.
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Durability and potency of the medications along with treatment adherence on the part of those infected are vital for viral control and long-term success. These modern drugs certainly provide the former and assist with willingness to adhere, but many patients are still taking regimens started 15 years ago. A popular regimen of the late 90’s involving three pills twice daily is now taken as two pills once daily with no loss of viral control over that period and restoration to essentially normal immune function. The majority of people living with HIV (PLWH) will die with, rather than of, their infection.

Drug/Drug interactions. DDIs continue to pose risks for those infected with the virus and medico-legal risks for doctors due to misadventure. They are numerous and unpredictable. Significant examples include alterations in drug metabolism such as prescribed and over the counter inhaled steroids and injected depot steroids leading to adrenal shutdown and rhabdomyolysis with statins in PLWHA taking drugs that inhibit the CYP 450 or Pgp enzyme systems.

Cardiac arrhythmias occur in patients prescribed erythromycin and taking protease inhibitors that may prolong the QTc interval. Loss of viral control can occur in patients prescribed H2 antagonists or proton pump inhibitors and taking HIV medications that require an acid environment for absorption. The use of cations such as Ca, Mg, Zn and Fe that bind to the active site of Integrase Inhibitors will inhibit their antiviral activity.

Lismore Sexual Health Service is happy to field calls at any time or DDIs can be researched at HIV Drug Interactions, an easy to use Newcastle UK website.

Treatment as Prevention (TasP). Two landmark studies published over the last three years demonstrate that suppression of the virus in PLWH essentially eliminates onward transmission of the virus to sexual partners, whether extra protection (condoms) are used or not. HPTN052, released in July 2011, demonstrated >96% effectiveness in reduction of transmission to the uninfected partner. This was mostly in heterosexual couples. The PARTNER study, early data from which was released in March 2014, demonstrated zero linked transmissions between homosexual partners with the full study results to be released in 2017. Statistical analysis predicts >96% protection also.

Pre (PrEP) and Post (PEP) Exposure Prophylaxis. Evidence is mounting that the use of antiretroviral drugs in those not infected but at risk, both prior to and after a risk event, significantly reduce infection rates. PEP starter packs are available through all local Emergency Departments for those presenting within 72 hours of a risk event, guidelines inform the suitability of an attendee for this. PrEP will become available in the near future as part of the NSW HIV Strategy through participating public clinics.

NSW HIV Strategy. The ambitious goal of this strategy is to decrease new HIV infections by 80% by 2020. To that end there is a three-

HIV - a new world

cont from p23

STI Screening in men who have sex with men

Sexually transmitted infections are shown to increase risk of HIV infection

6 monthly testing, more often if highly sexually active

HIV Antibody
Syphilis test (RPR for those previously treated)
Hepatitis A (vaccination recommended if non-immune)
Hepatitis B (vaccination recommended if non-immune)
Hepatitis C (in those who use injecting drugs or are HIV +ve)

Throat swab - gonorrhoea and chlamydia PCR
Anal swab – gonorrhoea and chlamydia PCR
First void urine or urethral swab - chlamydia PCR

pronged approach. Firstly, identify those already infected with the virus who are unaware of the infection. This has involved ramping up testing rates including reaching those who have not or who are reluctant to test and includes such initiatives as Point of Care testing outside traditional clinical venues and key performance indicators for publicly funded services. Home based testing is soon to be made available.

Secondly, early treatment initiation, after appropriate patient discussion and agreement, to improve long term outcomes for the patient and decrease onward transmission of the virus to sexual contacts. Thirdly, the strengthening of education measures currently employed to reduce transmission such as encouraging the use of condoms and clean drug injecting equipment, and now the TasP, PEP and PrEP messages.

HIV Support Program (HIVSP). GPs are urged to lower their threshold of risk assessment for HIV testing and test more often. Whilst men who have sex with men are most at risk of infection in Australia, significant numbers of those from and those travelling to high prevalence countries are being diagnosed with the infection. The HIVSP initiative aims to support GPs with little experience in HIV in delivering the news of a positive result to a patient and in achieving the best outcome. NSW Health is notified of a new diagnosis by the laboratory and informs the local HIVSP coordinator who will contact the GP or other diagnosing doctor to offer support, information and management pathways for both the doctor and the patient.

This is a brave new world for those infected with the virus and those at risk. Viral control restores the immune system and allows resumption of a full, active life with few restrictions. HIV infection is now a chronically manageable infection which requires the same planning as that involved in caring for other similarly long term conditions.

References:

1. ASHM Post-Exposure Propphylaxis after Non-Occupational and Occoupational Exposure to HIV - National Guidelines
2. ASHM Post-Exposure Prophylaxis Checklist

UK doctors in Australia

by Dr Edwin Kruys

- Why they won't be going home any time soon

First published in Dr Edwin Kruys' Doctor's Bag.

The numbers are telling: About 1,500 UK doctors move to Australia and New Zealand each year. This exodus is causing havoc in England. A GP-shortage creates high workloads and overstretched doctors, and a survey showed that over half of UK GPs plan to retire before the age of sixty. This stressful situation has prompted a coming home campaign to entice doctors to go back to the United Kingdom.

Why are doctors leaving, and, will they move back to save the NHS?

Dr Nathalie Departe is a UK-trained GP working in Fremantle, Western Australia. "I moved to Australia in 2009 for a change of scenery. I had visited Australia before and loved it, so when my husband found himself in a career hiatus, we thought we would enjoy the sunshine for a few years."

"Working in Australia was a breath of fresh air. Patients were pleased to see me, understanding if I ran late, and I was rewarded and not penalised if I spent time with a complex patient to sort out their management. Access to pathology and radiology services was prompt, rather than a standard 6-8 week wait for an ultrasound, and access to allied health services didn't compare – good luck trying to see a clinical psychologist on the NHS."

"Initially it was a bit odd to bill patients and not provide free care at the point of need, but I soon came to value the transparency of the transaction. The integration between private and public care makes private care accessible and affordable in Australia, rather than in the UK where private care has to be funded in full."

Escaping the NHS

"In Australia I can arrange imaging quickly, receive the results the next day and organise appropriate and timely care

Dr Janaka Pieris moved to Brisbane in 2010 to 'escape' the NHS: "When I think back to my working life as a GP in South East London, I have two overriding memories: there was never enough time in the day to do the work asked of me, and there was no means of limiting my workload. NHS General Practice is a sink for everything no-one else will take responsibility for. Many GPs feel unable to decline these demands – many of which are not NHS work and therefore unfunded – and as a result, are drowning in work."

"When a patient presents with painless obstructive jaundice in the UK, I have no option but to refer in to hospital, because I have no access to appropriate imaging, or I cannot get it done in a timely fashion. In Australia I can arrange the imaging quickly, receive the results the next day, discuss the case with a specialist and organise appropriate and timely care. It is much more satisfying from a professional perspective."

Dr Tim Leeuwenburg made the move in 1999, immediately after his internship in the UK. He is now a GP at Kangaroo Island in South Australia. "I was married to an Aussie and always knew I'd be coming to Australia for love and a better lifestyle."

Dr Edwin Kruys is a general practitioner on the Sunshine Coast, Queensland. He blogs regularly on his website, Doctor's Bag, on Health Care, Social Media and eHealth. He can be reached via LinkedIn and Twitter.

"That was 15 years ago. Since then I've vicariously witnessed the demise of UK medicine – and am anxious that Australia doesn't make the same mistakes: Other professions trying to do doctors' work, capitation and performance payments, privatisation, walk-in clinics, phone advice lines, revalidation. They are all seemingly good ideas, but not evidence-based and all have served to emasculate the profession and increase the number of doctors seeking to retire, locum or emigrate from the cesspit that is the NHS. None of these measures have reduced costs or increased quality."

> **"The myth of the 'fat cat' wealthy GP laughingly enjoying his round of golf whilst poor patients helplessly waited for his attentions was regularly portrayed in the media."**

Departe: "Despite working in a nice area and enjoying my job, I had a growing sense of unease with the way UK general practice was going. There seemed to be ever changing targets to qualify for practice payments with increased red tape and less time for consultations."

UK doctors in Australia

cont from p25

"There was a general loss of respect for the role of a GP; it was not unusual for patients to demand medication, tests and home visits inappropriately, then to be outraged if you questioned the need for it. The myth of the 'fat cat' wealthy GP laughingly enjoying his round of golf whilst poor patients helplessly waited for his attentions was regularly portrayed in the media, and I felt that general practice was being devalued in the eyes of public and politicians alike."

Dr Mark McCartney left the UK in 2013 because he was not happy with the working conditions in the NHS, but moved back to England after 12 months because of family circumstances. "There is a huge cultural difference in Australia, where there is a mixed health economy of private and state-subsidised services. The NHS is free at the point of access for patients, and service always struggles to meet the demand and prioritise appropriately. UK hospitals are dysfunctional places and the effects of this trickle into General Practice."

"UK GPs are mostly paid on the basis of capitation payments depending on the number of patients registered, with additional payments for reaching clinical targets and a small amount of fee for service payments. There is now a shortage of GPs and we work in an environment of running faster and harder just to meet demands, without additional incentives or resources."

"Australian GPs have the luxury of earning a high proportion of income from fee-for-service payments, including patient fees and Medicare payments. The more patients they see and the more services they provide, the more they earn. Clinical practice is also more interesting with rapid access to x-rays and scans. It is a professionally motivating environment to work in."

Would you move back to the UK?

Dr Pieris is sceptical about the fully funded induction and returner scheme: "Firstly, it is manifestly insulting to suggest that doctors who have worked in similar systems, such as Australia, need retraining to work in UK general practice. I do more medicine in Australia than ever I did in the UK."

"Secondly, if people are leaving because of a failed system, a sensible approach would be address those failings, not try to tempt people back into the same environment they left."

"To return would require most GPs to undertake 6-12 months of supervised training, and to surrender to ridiculous bureaucratic imposts

Departe: "Why would I return to a role where I am restricted in my clinical practice by financial constraints, strangled by paperwork, stressed out by time pressures, undervalued by patients and politicians and where I would earn less money for more work and more stress?"

"To return would require most GPs to undertake 6-12 months of supervised training, and to surrender to ridiculous bureaucratic imposts," says Leeuwenburg. "The reason doctors are leaving the NHS is because of unfettered demand from patient 'wants' not 'needs', and reduced income as a result of capitation. Why on earth would you go back?"

McCartney: "Very few GPs will return, unless they have personal or family reasons. UK GPs are retiring early, but this does not seem to be the case in Australia. There are also huge barriers to doctors wishing to move back to the UK in terms of medical registration and licensing to practice. The NHS is wasting resources trying to recruit in Australia and they look foolish because of that."

Doctor's advice

"My message for governments," says Departe, "would be Stop undervaluing good general practice! Good general practice has been proven to provide better value for money and a more integrated care approach than secondary care. By all means, regulate general practice to maintain appropriate standards of care but then pay us accordingly and let us get on with being general practitioners."

Leeuwenburg: "Listen to grassroots doctors, not NHS managers who have destroyed the NHS and are now sprucing their wares in Australia. Nor to academics who think things like capitation and revalidation are necessary. Our Australian system is marvelous and we should be proud. Sure, there is fat in the health system that could be trimmed, mostly in hospitals and specialists, but primary care is overall incredibly efficient and GPs do a great job."

"The UK government needs to stop attacking GPs and listen to doctors and the BMA, who have been largely ignored for the last ten years

"Ofcourse there are some outliers, but there are many more who are hard working and ethical, doing the right thing for patients and Medicare. Alienate GPs and risk the collapse of a great primary care system. It will cost more if we surrender to the failed experiments of the UK or privatise us with private health funds."

"The UK government needs to stop attacking GPs and listen to doctors and the BMA, who have been largely ignored for the last ten years," says McCartney. "Doctors want to work in an effective service so that they can focus on caring for patients. Learn from Australia that good access to radiology for GPs can keep people away from hospital until they really need to be there."

Pieris: "The UK Government should let us do our jobs. Trust us. Stop interfering. No-one is saying regulation and scrutiny are not required. However, GPs are not some malign enemy. Stop treating us as if we are."

Book Review

Editor GPSpeak

Robin Osborne

Being Mortal

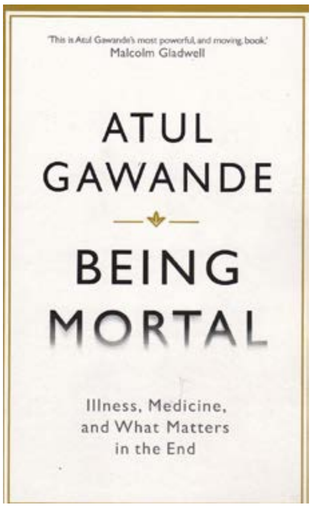
by Atul Gawande

(Profile Books 282 pp)

In an earlier review I described Atul Gawande's The Checkist Manifesto as required reading for those in the medical profession or any line of work that entails identified outcomes, team work and the serious consequences, professional or financial, of error.

The same may be said of this discussion of end-of-life issues, which he encapsulates in the sub-title, 'Illness, Medicine, and What Matters in the End.'

Dr Gawande explains, "This is a book about the modern experience of mortality – about what it's like to be creatures who age and die, how medicine has changed the experience and how it hasn't, where our ideas about how to deal with our finitude have got the reality wrong."



The backdrop is that, "no single disease leads to the end; the culprit is just the accumulated crumbling of one's bodily systems while medicine carries out its maintenance measures and patch jobs... The curve of life becomes a long, slow fade."

He describes this process as One Damn Thing After Another, the 'ODTAA syndrome' wherein the "pauses between crises can vary. But after a certain point, the direction of travel becomes clear."

Dr Gawande is a modern-day medical superstar, born of Indian immigrant doctor parents, a practising surgeon in Boston, Harvard professor, contributor to a wide range of journals, including The New Yorker, and well published author.

He could be forgiven for resting on his laurels, but there's no sign of slowing up, and this latest effort taps into a key debate of our time - how should, and can, society care for the ageing population?

Getting straight to the point, he writes, "People live longer and better than at any other time in history. But scientific advances have turned the processes of ageing and dying into medical experiences, matters to be managed by health care professionals. And we in the medical profession have proved alarmingly unprepared for it."

Moreover, as he adds, "This reality has been largely hidden, as the final phases of life become less familiar to people."

In the mid-20th century, most deaths occurred at home, while only 17 per cent did by the 1980s. This is changing again, with 45 per cent of Americans dying in hospice care, more than half of these at home.

The reason, he suggests, is that countries go through three stages of medical development that parallel their economic situation: those living in poverty mostly die at home, those in improved circumstances can turn to health care systems for support, while at the third stage, as incomes climb to the highest levels, "people have the means to become concerned about the quality of their lives, even in sickness, and deaths at home actually rise again."

The changing pattern of how we manage the last days - months, or years - of our older citizens' lives has taxed the author's mind for some time, fuelled by his interactions with seriously ill (but not always terminal) patients, and, in the most personal part of this book, by the passing of his beloved father.

Diagnosed with an advanced spinal tumour, Dr Gawande Snr received disparate advice from two leading surgeons. One advocated urgent intervention, to be followed by extensive follow-up treatment and rehab, the other a 'wait and watch' approach that would eventually lead to surgery but in the meantime provide a better quality of life.

Dr Gawande Jr, along with the patient and family members, supported the latter course, wisely as it turned out.

His father continued operating for some time, enjoyed his "chapatis, rice and split-pea dal", sorted through photos, advised the Rotary chapter he had led for years, and worked on the village healthcare foundation he had established back in India.

"The medicine did a good job of preventing pain," his son recalls. "What he wanted for the final lines of his story, now that nature was pressing its limits, was peacefulness."

Addressing the issue of assisted death, Gawande writes that, "Certainly, suffering at the end of life is sometimes unavoidable and unbearable, and helping people end their misery may be necessary.

"But we damage entire societies if we let providing this capability divert us from improving the lives of the ill. Assisted living is far harder than assisted death, but its possibilities are far greater, as well."

He raises a major concern about the lack of geriatricians, both now and even more so in the future when they will be increasingly needed, advocating that all primary care doctors and nurses be upskilled in caring for the very old.

Quoting one such specialist, he says, "We've got to do something. Life for older people can be better than is it today."

If there's one key message from this excellent and timely book, this is it.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